TRICARE Standard Provider Handbook

September 1998

Department of Defense
Office of the Assistant Secretary of Defense for Health Affairs
TRICARE Management Activity

Foreword

The purpose of this Handbook is to provide program information and guidance for health care providers in delivering health care and services to TRICARE beneficiaries.

Be aware that this Handbook does not cover all policies and procedures of TRICARE. Rules and the benefits change over time.

It is important to be in touch with the Managed Care contractor for your region.

The final authority for the TRICARE program is 32 CFR 199. If there is a discrepancy between this Handbook and 32 CFR 199, these regulations determine benefits.

Comments regarding this Handbook should be sent to:

Public Affairs Branch
TRICARE Management Activity
16401 East Centretech Parkway
Aurora, CO 80011-9043

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TRICARE

TRICARE is a health care program overseen by the Department of Defense in cooperation with regional civilian contractors. TRICARE began in March 1995 in Washington and Oregon and has expanded into all areas of the country. Military Lead Agents are responsible for the program in each region.

TRICARE provides three options to eligible beneficiaries: TRICARE Prime, similar to a health maintenance organization; TRICARE Extra, a preferred provider option that saves money for patients; and TRICARE Standard, a fee-for-service option, which is the same as the former CHAMPUS, the Civilian Health and Medical Program of the Uniformed Services.

Providers who are interested in becoming part of a TRICARE network should contact the TRICARE contractor for the appropriate region.

This Handbook addresses TRICARE Standard's procedures and benefits.

Note: Providers who have Internet access will find extensive coverage of TRICARE on the Web site for the TRICARE Management Activity–Aurora. Web address: www.tso.osd.mil

TRICARE Standard

TRICARE Standard is a cost-sharing program for military families, retirees and their families, some former spouses, and survivors of deceased service members. The uniformed services covered include the Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service and the National Oceanic and Atmospheric Administration.

The program shares the cost of most medical services from civilian providers when beneficiaries cannot get care from a military hospital or clinic. Service families are eligible to receive inpatient and outpatient care from uniformed service hospitals and clinics. The types of medical services available at uniformed service hospitals vary by facility, and hospitals serve active-duty service members first.

TRICARE Standard is similar to other third-party payers in that there are some coverage limitations and personal financial responsibilities. Providers should check with the contractor for their state if there are questions about coverage of certain types of care.

TRICARE Standard covers medically necessary services and supplies required for diagnosis and treatment of illness or injury, including maternity care. Physicians and other authorized providers must deliver services and supplies in accordance with sound medical practice and established quality standards.

CHAMPVA

CHAMPVA (The Civilian Health and Medical Program for the Veterans Administration) is a health benefit program for the families of veterans with 100 percent service-connected disability and the surviving spouse or children of a veteran who dies from a service-connected disability. The Department of Veterans Affairs determines eligibility and processes CHAMPVA claims. Questions concerning coverage should be directed to:

Health Administration Center
300 S. Jackson St.
P.O. Box 65023
Denver, Colorado 80206-5023
1-800-733-8387

TRICARE Standard Covered Services

Note: This is not an all-inclusive list. See the Web site for additional information.

- Ambulance
- Ambulatory surgery
- Anesthesia services
- Bone marrow transplants (with limitations)
- Breast reconstruction (with limitations)
- Chronic renal disease
- Consultation services
- CT scans
- Diagnostic testing
- Durable medical equipment
- Family planning, including prescription contraceptives
- Free-standing birthing centers
- Hospice care (see section on hospice care for specifics)
- Inpatient care
- In-home cardio-respiratory monitors
- Laboratory and pathology services

- Magnetic resonance imaging (with limitations)
- Mammograms (see section on mammograms for specifics)
- Maternity care
- Medical supplies and dressings
- Mental health care (with limitations or authorization required)
- Morbid obesity (with limitations)
- Norplant contraceptives
- Outpatient care
- Oxygen
- Pap smears (see section on pap smears for specifics)
- Partial hospitalization for mental health
- Percutaneous lithotripsy (kidney stones only)
- Percutaneous transluminal coronary angioplasty
- Physical therapy
- Prescription drugs and medicines
- Prosthetic devices
- Speech therapy (with limitations)
- Sterilization
- Radiation therapy services
- Surgery (pre-operative and post-operative care)
- Transplants (see section on transplants)
- Well-child care (birth to 17 years)
- X-ray services

Non-Covered Services

Note: This is not an all-inclusive list. See the Policy Manual on the Web site for excluded services.

- Acupuncture
- Anesthesia by surgeon
- Artificial insemination
- Breast reduction or augmentation (cosmetic purposes)
- Chiropractic care
- Comfort items
- Cosmetic surgery (with exceptions)
- Custodial care
- Domiciliary care
- Electrolysis
- Exercise programs
- Immunizations (limited benefit). See Note below.
- Unproven procedures or treatments
- Naturopaths
- Routine physical examinations
- Radial keratotomy/Photorefractive keratectomy
- Routine foot care
- Sterilization reversal
- Stop smoking programs
- Vitamins
- Weight reduction programs

Note: Immunizations are covered for the following diseases according to the current Centers for Disease Control Advisory Committee on Immunization Practices recommendations: tetanus, diphtheria, pertussis, poliomyelitis, mumps, measles, rubella, influenza, pneumococcal disease, haemophilus influenza type B, hepatitis A, hepatitis B, and varicella. Well-child immunizations from birth to under six years are covered when administered according to the

recommendations of the current Center for Disease Control and Prevention Advisory Committee on Immunization Practices.

Physical exams are covered when provided for TRICARE Standard patients who are being transferred overseas.

Covered Oral Surgery

- Surgery to correct accidental injury
- Medically necessary surgery of accessory sinuses, salivary glands or ducts
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when the condition requires a pathological exam
- External incision and drainage of cellulitis
- Fractures of facial bones
- Correction of cleft palate
- Oral and facial cancer
- Reduction of dislocations and the excision of the temporomandibular joints, when surgery is a necessary part of the reduction
- Surgical intervention necessitated by physician-induced trauma

Note: Covered oral surgical procedures that are essentially medical rather than dental may not require pre-authorization. Contact your claims processing contractor to determine whether a planned oral surgery procedure requires preauthorization.

Non-Covered Dental Services

- Preventive, routine, restorative, prosthodontic and emergency dental care
- Adding or modifying bridge work and dentures
- Orthodontics, except when directly related to correction of a cleft palate

Note: Pre-authorization is needed for adjunctive dental care.

Providers should contact the appropriate contractor.

Note: The TRICARE Active-Duty Family Dental Plan is not part of the TRICARE medical benefits program. The Reserve Dental Plan and the Retiree Dental Plan are separate insurance programs administered by civilian contractors.

Eligibility

Providers should check for a valid military ID card or authorization letter, check the expiration date, and make a copy of both sides of the ID card.

Providers should ask TRICARE Standard patients whether they are enrolled in DEERS. Patients can verify their enrollment by calling the nearest personnel office of any service, or by calling the DEERS center:

U.S.:	1-800-538-9552
California only:	1-800-334-4162
Hawaii and Alaska:	1-800-527-5602

Note: Providers may not verify DEERS enrollment directly because of the Privacy Act.

Children under the age of 10 will probably not have an ID card. In these cases, providers should check the parent's ID card.

The TRICARE Management Activity (TMA)-Aurora, formerly known as OCHAMPUS, recommends that providers make a copy of both sides of the ID card and retain it on file for future reference. Some patients may tell you that it isn't legal to copy ID cards, but it is legal for these purposes.

Note: See Appendix B for Examples of ID Cards.

Note: Family members lose their eligibility at midnight on the day the active-duty sponsor is discharged from service unless they have extended benefits as a result of their service in the Gulf War or because of an incentive to separate from military service.

Active-duty service members are not covered by TRICARE Standard. They are automatically enrolled in TRICARE Prime. The service member's branch of service provides for the care of active-duty service members, or is responsible for paying for any civilian emergency care required by active-duty members. All claims for active-duty members must be referred to the member's branch of service.

Special Eligibility Rules under Diagnosis Related Groups (DRGs)

Under the TRICARE Standard DRG payment system, if a patient loses or gains eligibility during a period of hospitalization, the DRG hospital will be paid as if the patient were eligible during the entire confinement. If the patient loses eligibility because of gaining Medicare eligibility, TRICARE Standard becomes the secondary payer. For a patient who becomes eligible for Medicare because of age and who isn't an active duty dependent, TRICARE's second pay status is FOR THAT CLAIM ONLY. However, a change in eligibility often will affect outlier payments. The patient's cost-share will be based on the status of the sponsor (active-duty or retired) at the *time of admission. For all other providers, including DRG-exempt hospitals, TRICARE Standard will share the cost of only that portion of the services or supplies that were rendered before eligibility ceased*.

Inpatient Care and Non-Availability Statements

TRICARE Standard patients who live within the health care zone, generally a 40-mile radius (ZIP code zone) around a uniformed service hospital, need a non-availability statement (DD Form 1251) issued by the uniformed service hospital before getting non-emergency inpatient civilian care. However, TRICARE Standard will share the cost of non-emergency inpatient care without a non-availability statement when the patient has a non-TRICARE Standard health plan that is first payer. TRICARE-eligible families who live outside the ZIP code zone of the nearest uniformed service hospital don't have to get non-availability statements for inpatient civilian health care.

Providers should be aware that the issuance of a non-availability statement by a military hospital does *not guarantee payment nor does it authorize the TRICARE Standard benefit*.

TRICARE Standard does not require non-availability statements for emergency treatment, but the attending physician must certify that the episode was a true emergency. The contractor will check the diagnosis to verify the emergency. On the UB-92, Code 1 must be inserted in Locator 17.

Note: TMA recommends sending the medical documentation of the emergency with the claim.

If a patient received emergency treatment in one hospital and was transferred to another hospital for the same diagnosis because the first hospital was unable to treat him or her, the services by the transferring hospital can be cost-shared as inpatient services.

An emergency is defined as the sudden and unexpected onset of a medical condition, a severe injury, or an acute exacerbation of a chronic condition that is threatening to life, limb or sight, requiring immediate treatment. Additionally, it may involve painful symptoms requiring immediate palliative efforts to relieve suffering. Providers should direct questions about the definition of an emergency to the appropriate contractor.

The following services do not, at present, require a non-availability statement:

- Ambulatory surgery
- Inpatient services in substance use disorder rehabilitation facilities, skilled nursing facilities, student infirmaries and residential treatment centers
- Institutional care under the Program for Persons with Disabilities (formerly called Program for the Handicapped)
- Maternity care and birthing services at a TRICARE Standard-authorized birthing center or a hospital-based birthing room

Note: There are requirements for pre-authorization for transplantation. Providers should contact the TRICARE contractor's medical director, the health care finder, or other designated utilization staff for information and pre-approval.

Specialized Treatment Services Facilities (STSFs)

There are several military medical centers and one joint medical center for certain types of care.

For heart surgery and related treatment of heart disease, there are four facilities: Eisenhower Army Medical Center at Fort Gordon, GA; Walter Reed Army Medical Center in Washington, D.C.; National Naval Medical Center, Bethesda, MD; and Keesler Medical Center, Keesler Air Force Base, MS. Patients who live within a regional STSF ZIP code, generally a 200-mile radius around an STSF, must get their treatment there or be issued non-availability statements, unless the treatment is for an emergency or the care is covered by other health insurance.

Keesler Medical Center is also an STSF for neonatal intensive care.

For allogeneic bone marrow transplantation, Wilford Hall Air Force Medical Center in San Antonio is the national Specialized Treatment Services (STS) facility. All patients whose care will be paid for with TRICARE funds must be evaluated by Wilford Hall before getting the transplant. If Wilford Hall cannot perform the transplant, a non-availability statement will be issued.

The New Mexico Regional Federal Medical Center (NMRFMC) is a joint Air Force and Veterans Administration facility in Albuquerque serving as a national specialized treatment facility for advanced neuro-imaging. A non-availability statement is not required, but prior approval is necessary before obtaining services from NMRFMC.

Additional STSFs are being designated. For information, providers should check with the TRICARE managed care support contractors.

Note: Physicians can find points of contact for the medical centers listed in a news release (April 10, 1997) on the subject under Public Affairs on the Web site: www.tso.osd.mil

Validity of Non-Availability Statements

Non-availability statements remain valid for admissions occurring within 30 days of issuance and for 15 days after discharge for any additional inpatient treatment directly related to the original admission.

With maternity care, the date of admission is the date the patient enters a prenatal program with a civilian provider. The non-availability statement remains valid until 42 days following the termination of the pregnancy.

If a newborn remains in the hospital continuously after discharge of the mother, the mother's non-availability statement remains valid for up to 15 days after the mother's discharge. After that, a non-availability statement in the baby's name must be obtained.

If the newborn is the child of a mother who's on active military duty, a non-availability statement is required on the fourth day of care. The same rule applies to the illegitimate newborn of an active-duty or retiree father and an ineligible mother.

Note: See DEERS section on registering newborns.

Automated Non-Availability Statements

Non-availability statements need not be sent with claims from civilian hospitals. The process is automated, and the military hospital will file the non-availability statement with DEERS if the patient lives within the ZIP code service area. The contractor will recognize only those non-availability statements entered electronically into DEERS.

Ambulance Coverage

TRICARE shares the cost of ambulance service as an outpatient service under program rules. However, ambulance transfers between hospitals are cost-shared on an inpatient basis. TRICARE will share the cost of ambulances from a civilian hospital to a uniformed service facility.

Ambulance transportation must be medically necessary (patient would otherwise be at risk); the patient's illness or injury must be covered under TRICARE; and the ambulance must be licensed under state or local law. The following patient conditions meet the medical necessity requirement:

- was transported in an emergency situation, e.g., as a result of accident, injury, or acute illness, or
- needed to be restrained, or
- was unconscious or in shock, or
- required oxygen or other emergency treatment on the way to his or her destination, or
- was experiencing severe hemorrhaging, or
- has to remain immobile because of fracture that had not been set or the possibility of a fracture, or
- sustained an acute stroke or myocardial infarction, or
- was bed-confined before and after the ambulance trip, or could be moved only by stretcher.

If the above conditions are absent, providers should submit additional documentation to establish medical necessity.

Taxis, medicabs and ambicabs do not qualify as ambulances.

Boats and airplanes can qualify as ambulances when the pick-up point is inaccessible by land, is a long distance from a hospital, or when the patient's condition requires speedy hospital admission. Boats and airplanes must be specifically designed vehicles for transporting the sick or injured.

Reusable devices and equipment must be included in the charge for the ambulance trip. Ambulance providers may charge separately for non-reusable items and disposable supplies, based on actual quantities used.

TRICARE will not pay for separate charges for ambulance personnel.

Claims for ambulance service should be submitted on the HCFA 1500 or, when the ambulance is hospital-owned, on the UB-92.

Ambulatory Surgery

Surgery performed on an outpatient basis at a freestanding ambulatory surgical center must meet all of the following conditions to be payable under TRICARE:

- A physician prescribes, provides or supervises the treatment.
- The center provides the type and level of care and services authorized by TRICARE rules. Ambulatory surgery is defined as surgery done on an outpatient, walk-in basis, with no overnight hospital stay required.
- The center meets all licensing and certification requirements of the jurisdiction where the facility is located.
- The center is approved by Medicare, accredited by Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care (AAAHC), or meets other such standards as required by TRICARE.
- The surgical procedure must be one approved by TRICARE as ambulatory surgery.

Ambulatory surgery is cost-shared as inpatient care for active-duty family members.

TRICARE Standard pays for ambulatory surgery by using prospectively determined rates that are divided into ten payment groups that represent ranges of costs, adjusted for labor rates based on Metropolitan Statistical Areas used by Medicare.

Payment rates for approved procedures apply only to the facility charges. The facility rate includes use of the facility, equipment related to the surgical procedure, nursing and technician services, most drugs, surgical dressings, splints, casts, materials for anesthesia, intraocular lenses, and administrative and housekeeping items and services.

Facility charges must be submitted on either the HCFA 1500 claim form or the UB-92. Professional charges must be submitted on the HCFA 1500. TRICARE cannot share the cost of professional services provided by employees salaried by or contracted with non-approved centers.

Facility rates do not include providers' fees, diagnostic procedures, prosthetic devices, ambulance services, braces, artificial limbs, or durable medical equipment to be used by the patient at home. Providers should submit claims separately for items not included in the facility rate. Claims from ambulatory surgical centers that participate in TRICARE Standard will be reimbursed at the appropriate rate, regardless of the facility charges. If the facility is non-participating, payment cannot exceed the lesser of the billed charge or the payment rate.

TRICARE Standard cannot cover facility charges for procedures performed by a free-standing ambulatory surgical center unless they're on the TRICARE list of covered procedures. A surgical procedure performed by a hospital, either in an emergency room or in an outpatient department, but

which isn't considered by TRICARE to be ambulatory surgery, may be reimbursed based on the billed charges, and cost-shared as an outpatient service.

If Medicare makes any changes to its list of approved ambulatory surgical procedures, TRICARE will also make the change to the TRICARE list. Providers may check with the appropriate contractor to determine whether a given procedure is on the list of approved procedures.

Allowable Charge Reviews

The contractor may review disagreements regarding the amount allowed for a particular claim, upon request. This includes disagreements with the application of TRICARE Claimcheck edits. Requests for review must be sent to the contractor processing the claim and must be postmarked within 90 days of the date on the Explanation of Benefits.

The decision of the contractor is final.

Appeals

Appealing Benefit Decisions

Participating providers may appeal certain decisions made by the contractor or by the TMA-Aurora. Generally, providers who do not participate may not appeal, but TRICARE Standard patients, parents of patients under 18, or guardians of incompetent beneficiaries are proper appealing parties and may file appeals. A proper appealing party may appoint someone (including a participating or non-participating provider) to represent him or her in the appeal. Generally, providers who do not participate may not receive any information regarding claims without the signed authorization of the patient, the patient's parent or guardian, or the patient's appointed representative.

The appeals process varies depending upon whether the denial of benefits involves a medical necessity determination or a factual determination. All initial and appeal denial determinations include a section fully explaining where and how to file the next appeal.

1. ***Medical necessity determinations*** are those based solely on medical necessity, appropriate level of care, or custodial care, as these terms are defined in 32 CFR Part 199.2, or other reasons relative to reasonableness, necessity or appropriateness. Determinations relating to mental health benefits under 32 CFR 199.4 are considered medical necessity determinations. The appeal process that applies to adverse medical necessity determinations is:

    - A reconsideration conducted by the managed care support contractor.
    - A second reconsideration conducted by the National Quality Monitoring Contractor (NQMC).
    - If services have been provided, a hearing administered by the TMA Office of Appeals and Hearings and conducted by independent hearing officers. The sole issue addressed at a hearing requested by a provider is whether the provider knew or could reasonably have been

expected to know that the denied services were excludable. This means that the medical necessity of the services is not addressed at the hearing.

2. ***Factual determinations*** are issued in cases involving something other than medical necessity. Examples of factual determinations are those involving:

   - Coverage issues (e.g., whether a service is covered under TRICARE policy)
   - Provider authorization (status) requests
   - Provider sanction cases
   - Hospice care
   - Denials based on sections other than 32 CFR 199.4
   - Foreign claims
   - A mix of both medical necessity ***and*** factual determination issues

   The appeal process that applies to adverse factual determinations is:

   - A reconsideration conducted by the managed care support contractor
   - A formal review conducted by the TMA Office of Appeals and Hearings
   - If services have been provided, a hearing administered by the TMA Office of Appeals and Hearings and conducted by an independent hearing officer

In provider sanction cases, the initial denial determination is appealed directly to a hearing, bypassing the reconsideration and formal review levels of appeal.

Decisions Affecting a Provider's Authorized Status under TRICARE

Providers who request approval as TRICARE-authorized providers but are denied approval by either TMA or the contractor may appeal those decisions and request a reconsideration. Providers who are terminated, suspended or excluded from TRICARE may appeal those decisions and request a hearing. However, providers who are not eligible for authorization by TRICARE because of fraud and abuse against another federal or federally funded program or a state or local licensing authority, e.g., Medicare or Medicaid, may not appeal through the TRICARE system.

Non-Appealable Matters

Non-appealable matters include:

- Denial of services received from a provider not authorized to provide care under TRICARE
- A specific exclusion of law or regulation
- Allowable charges for a particular service

- Issues relating to the establishment and application of diagnosis-related groups
- Decisions by the contractor to ask for additional information on a particular case
- A determination of a person's eligibility as a TRICARE beneficiary

Attending Physicians

The term "attending physician" has been expanded to include other authorized health care providers, such as podiatrists, clinical psychologists, oral surgeons, certified physicians' assistants, certified nurse midwives, and others. In addition, the term "surgical assistant" now includes such providers as dentists and podiatrists, allowing them to assist with complex surgery when warranted.

Interns, residents, and fellows are not authorized providers and cannot establish an "attending physician" status for reimbursement purposes. If there is no record of an attending physician in the course of care, there is a possibility the government cannot reimburse for services.

Authorized Providers

A TRICARE Standard-authorized provider is one who meets certain educational, licensing and operational requirements. Institutional providers include hospitals, special institutional providers, skilled nursing facilities, residential treatment centers, Christian Science sanitoria, and infirmaries. The term does not include professional corporations or associations.

Generally, institutional providers must be Medicare- or JCAHO-approved, or meet other established program standards for the specific institution. For more information, contact the appropriate contractor.

Individual professional providers of care include those who bill on a fee-for-service basis and are not employed by or contracted with an institutional provider. This category includes physicians, dentists, physicians' assistants, clinical psychologists, optometrists, podiatrists and chiropodists, certified nurse midwives, certified nurse practitioners, clinical social workers, nurse anesthetists, independent laboratories, pharmacies, portable x-ray suppliers, ambulance and medical equipment suppliers, marriage and family therapists, physical and occupational therapists, and others.

TRICARE requires that physicians supervise some professional providers and that physicians refer patients. These include, among others, physicians' assistants, some counselors, licensed registered nurses, nurse anesthetists, audiologists, speech therapists, physical therapists, and occupational therapists.

Note: See section on Marriage and Family Therapists regarding payment as independent providers.

Providers must be licensed for their particular professions in the jurisdiction where the service is given. If licensure is not offered in the jurisdiction, the provider must be certified or prove eligibility for membership in the appropriate national or professional association that sets standards for the profession.

TRICARE requires that the contractors update their provider files every two years and within three months following a transition (change in contractors). Providers who have not submitted a claim within the previous 24-month period will be purged as inactive providers. The contractor will send active providers certification packets, with a specific deadline for returning the information. If providers don't return the information by the specified date, their claims will be denied.

A provider who has licenses to practice in two or more jurisdictions and has one or more license(s) suspended or revoked will be terminated as a TRICARE provider.

Note: Occupational therapists may bill TRICARE directly for services provided.

See section on Physicians' Assistants.

Benefit Authorization

TRICARE Standard requires prior approval of all care under the Program for Persons with Disabilities.

Providers may contact the contractor in their managed care regions.

TRICARE Standard does not provide pre-authorization for cosmetic, plastic or reconstructive surgery. However, providers should be aware that TRICARE does not pay for surgery of this type unless the purpose is clearly for restoration of function, to correct a serious birth defect, to restore body form after an accidental injury, to improve appearance after severe disfigurement or extensive scarring from surgery for cancer, or for breast reconstruction after a mastectomy.

Documentation establishing medical necessity must accompany these types of claims.

Many types of mental health care require pre-payment certification. See Mental Health section.

Adjunctive dental care requires pre-authorization. See section on Non-Covered Dental Services.

Pre-Authorization For Certain Procedures

TRICARE Standard no longer requires outpatient non-availability statements, but there are a number of procedures that require pre-authorization for all patients, including TRICARE Standard patients and those with other health insurance. The following procedures require pre-authorization:

- Arthroscopy (shoulder, elbow, wrist, knee, ligament, and ankle)
- Cardiac catheterization
- Diagnostic laparoscopy
- D&C for diagnostic or therapeutic reasons
- Upper gastrointestinal endoscopy

- Laparoscopic cholecystectomy
- MRI
- Rhinoplasty or septoplasty
- Tonsillectomy or adenoidectomy
- Breast mass or tumor excision
- Cataract removal
- Cystoscopy
- Hernia repair
- Ligation/transection of fallopian tubes
- Myringotomy or tympanostomy
- Neuroplasty
- Strabismus repair

Providers should be aware that there may be additional procedures that need pre-authorization. These are usually high-cost procedures. Providers should contact the contractor or a health care finder for information.

Biofeedback

TRICARE shares the cost of services and supplies when used in connection with electrothermal, electromyograph and electrodennal biofeedback therapy for patients who have not responded to more conventional treatment. Coverage requires physician evaluation and referral of patients to TRICARE-authorized providers.

Coverage is limited to adjunctive treatment for the following conditions:

- Raynaud's syndrome
- Muscle re-education of specific muscle groups, treatment of pathological muscle abnormalities of spasticity or incapacitating muscle spasm or weakness

Excluded is biofeedback for treatment of ordinary muscle tension states, for migraine or tension headache, psychosomatic conditions, bladder-control or hypertension. TRICARE also excludes payment for the rental or purchase of biofeedback equipment.

TRICARE Standard limits treatment to 20 sessions (inpatient and outpatient) in a calendar year for each patient, excluding the initial evaluation.

Claims must document physician referral, appropriate medical evaluation and previous attempts at conventional treatment and indicate whether the patient's condition is expected to improve with the therapy.

Breast Reconstruction

TRICARE covers breast reconstructive surgery following a medically necessary mastectomy (cancer, fibrocystic disease, non-cancerous tumors or serious injury). There is no time limitation between the mastectomy and reconstruction.

The Food and Drug Administration must approve any implant material for use in humans.

Breast Construction

TRICARE will share the cost of constructive breast surgery when the absence of a breast is due to an identified congenital anomaly. Documentation must show that a congenital anomaly existed which resulted in agenesis of the breast, i.e., Poland's Syndrome. Reconstructive surgery for an incomplete or underdeveloped breast is not covered.

Breast Reduction

TRICARE limits coverage of breast reduction to surgery primarily performed to relieve severe pain, which is a result of excessively large, pendulous breasts, when the pain cannot be relieved by other forms of treatment. TRICARE will cover reduction of the opposite breast in post-mastectomy reconstructive surgery to match the reconstructed breast.

Breast reduction to relieve severe pain is not covered unless symptoms have been present for at least one year and other very specific criteria are met.

Providers should contact the contractor in their area for more specific information and for assistance with the documentation that must accompany breast reduction claims.

Cardiac Rehabilitation

TRICARE shares the cost of some cardiac rehabilitation programs provided by TRICARE-authorized providers and ordered by physicians treating patients who have experienced the following cardiac events within the preceding 12 months:

- Myocardial infarction
- Coronary artery bypass graft
- Coronary angioplasty

- Percutaneous transluminal coronary angioplasty
- Chronic stable angina (limited to one treatment episode, i.e., 36 sessions, in a calendar year).

There is a limit of 36 sessions per cardiac event. Charges for initial evaluation and testing, and related professional services, are not included in the 36-session limit and may be billed separately. Use procedure codes 93797 and 93798 for all rehabilitation sessions. TRICARE will not allow additional payment for claims billed under code 93798.

Outpatient claims payment will be based on an all-inclusive allowable charge per session, including all related professional services provided during the session.

Inpatient claims payment will be based on the reimbursement system in place for the hospital where services are provided.

Cardiac rehabilitation programs that are not hospital-based or those designed primarily for lifetime maintenance, done at home or in medically unsupervised settings, are not covered.

Chronic Renal Disease (CRD)

Chronic or end stage renal disease that requires a continuing course of dialysis or a kidney transplantation to ameliorate uremic symptoms and maintain life is covered under TRICARE. When the patient is also eligible for Medicare Part A and has purchased Medicare Part B, benefits must be coordinated with Medicare for proper reimbursement. The patient or participating provider may bill TRICARE only after sending the claim to Medicare and receiving reimbursement. TRICARE will pay any deductible, cost-share or TRICARE-covered services that are *not covered under Medicare; TRICARE picks up what Medicare doesn't pay. A copy of the Medicare Explanation of Benefits (EOB) must accompany the TRICARE Standard claim form*. TRICARE Standard cannot pay benefits if the patient has not purchased Medicare Part B coverage.

CT Scans

Medically necessary computerized tomography of the head and body is covered when all of the following are met:

- A physician refers the patient for the diagnostic procedure.
- The CT scan procedure is consistent with the preliminary diagnosis or symptoms.
- Other non-invasive and less costly means of diagnosis have been attempted or are not appropriate.
- The CT scan equipment is licensed or registered by the appropriate state agency responsible for licensing or registering medical equipment that emits ionizing radiation.

- A physician supervises and directs the operation of the CT scan equipment.
- A physician interprets the results of the CT scan.

Claims for CT scan procedures must include the following information documenting medical necessity:

- Patient's preliminary diagnosis or symptoms
- Referring physician's name
- Physician's name who interpreted results, if other than the referring physician

CT scans performed by mobile units are subject to the same coverage requirements that apply to stationary units.

Demonstration Projects

DOD Cancer Treatment Clinical Trials

On Jan. 24, 1996, DOD announced the expansion of an existing demonstration for breast cancer treatment clinical trials to include all cancer treatment clinical trials under approved National Cancer Institute (NCI) clinical trials. The expansion includes all NCI-sponsored phase II and phase III clinical trials. TRICARE-eligible cancer patients who meet clinical criteria for participation in these studies must have advance approval for the treatment from the contractor.

The cancer patient's attending physician must do an initial evaluation and determine which clinical trials and participating medical institutions are available. The physician will then arrange for the patient's evaluation at the selected center. Program information and authorization are available from the contractor.

Physicians at the selected treatment center will make the eligibility determination, based on the clinical criteria for their study. Participating institutions include NCI's network of cancer centers, university and community hospitals and practices, and military hospitals.

DOD has extended the demonstration project to Jan. 1, 1999.

Other Demonstrations

TRICARE has some demonstration projects in various regions. These projects involve tests of alternative health care delivery methods.

Coverage in demonstration areas may differ from usual TRICARE Standard policy. Providers should contact the appropriate regional contractor to find out about any demonstration projects affecting their area.

Durable Medical Equipment (DME)

TRICARE Standard patients may rent, lease/ purchase or simply purchase durable medical equipment if the following criteria are met:

- The allowable charge must exceed $100.
- It must be medically necessary in treating a covered illness or injury.
- It must improve the function of a malformed, diseased or injured body part or retard further deterioration of the patient's physical condition.
- It must be person-specific and be provided on a one-at-a-time basis only.
- It must be primarily and customarily used to serve a medical purpose. DME is not covered if used primarily for transportation, comfort or convenience. Wheelchairs do qualify as DME since they provide mobility and retard deterioration. Cart-like vehicles may also qualify.
- It must withstand repeated use.
- It must be other than eyeglasses, contact lenses, hearing aids or other communication devices and must be other than exercise equipment, spas, whirlpools, hot tubs, swimming pools or similar items.
- It cannot be beyond the medically appropriate level of performance and quality required under the circumstances. Luxury or deluxe items do not qualify. Special fitting of equipment to accommodate a particular disability, e.g., a one-armed wheelchair, is covered.
- It is not for a patient in a facility that provides or can provide the equipment.
- It is not available from a local uniformed service medical facility, should one be in the area. A letter from the uniformed service facility must accompany the claim when the patient's address is within the ZIP code zone.

Under TRICARE Standard, DME may be purchased, rented or leased by the month, depending on the cost and period of medical necessity. The contractor will determine the most cost-advantageous position for the government. Patients may request cost-sharing over a one- to six-month period.

Note: TRICARE rules exclude air conditioners, humidifiers, dehumidifiers and purifiers (including electronic air filters), regardless of the patient's diagnosis. The denial of these items is not appealable.

TRICARE will share the cost of repair of DME that is already owned by a patient, subject to the following criteria:

- Repairs are limited to those required to make the equipment serviceable.
- The physician must state that the equipment continues to be medically necessary.

- The repair cost must be less than the rental or lease/purchase of a new unit.
- The need for repair must not be due to willful or malicious conduct on the part of the patient.

The attending physician must send a signed and dated statement with the claim for repair including:

- Patient's diagnosis
- Nature of the repair required
- Estimated length of medical necessity for the equipment

Fraud and Abuse

The TMA has a specific office to oversee the fraud and abuse program for the agency. The Program Integrity branch analyzes and reviews cases of potential fraud (intent to deceive or misrepresent to secure unlawful gain). Some examples of fraud are:

- Billing for services, supplies or equipment not furnished or used by the beneficiary.
- Billing for costs of non-covered or non-chargeable services, supplies or equipment disguised as covered items.
- Violation of the participation agreement that results in the beneficiary being billed for amounts that exceed the TRICARE Standard allowable charge or cost.
- Duplicate billings, i.e., billing more than once for the same service, billing TRICARE and the beneficiary for the same services, submitting claims to both TRICARE and other third parties without making full disclosure of relevant facts or immediate full refunds in the case of overpayment by TRICARE.
- Misrepresentations of dates, frequency, duration or description of services rendered, or the identity of the recipient of the service or who provided the service.
- Reciprocal billing, i.e., billing or claiming services furnished by another provider or furnished by the billing provider in a capacity other than billed or claimed.
- Practicing with an expired or revoked license, since an expired or revocation of licensure in any state or territory of the United States will result in a loss of authorized provider status under TRICARE.
- Agreements or arrangements between the provider and the beneficiary that result in billings or claims for unnecessary costs or charges to TRICARE.

The Program Integrity branch also reviews cases of potential abuse (practices inconsistent with sound fiscal, business or medical procedures and services not considered to be reasonable and necessary). Such cases often result in inappropriate claims for TRICARE payment. Some examples of abuse are:

- A pattern of waiver of beneficiary (patient) cost-share or deductible
- Charging TRICARE beneficiaries rates for services and supplies that are in excess of those charged the general public, e.g., commercial insurance carriers or other federal health benefit entitlement programs
- A pattern of claims for services that are not medically necessary, or if necessary, not to the extent rendered
- Care of inferior quality
- Failure to maintain adequate clinical or financial records
- Unauthorized use of the term "TRICARE" in private business

Providers are cautioned that unbundling, fragmenting, or code gaming in order to manipulate the CPT codes as a means of increasing reimbursement is considered an improper billing practice and a misrepresentation of the services rendered. Such a practice can be considered fraudulent and abusive.

Fraudulent actions can result in criminal or civil penalties. Fraudulent or abusive activities may result in administrative sanctions of suspension or exclusion as an authorized provider.

The TMA Office of General Counsel works in conjunction with the Program Integrity branch in dealing with fraud and abuse. The Defense Department's Inspector General and other agencies investigate TRICARE fraud.

Note: See also Provider Sanctions.

Hospice Care

TRICARE covers hospice care for terminally ill patients who have prognoses of less than six months to live if the illness runs its normal course. The TRICARE Standard benefit closely resembles Medicare's benefit.

There are no limitations on custodial care and personal comfort items under hospice care rules, as there are with other types of care. In addition, the hospice benefit has fewer restrictions than other types of TRICARE-covered care. For example, hospice care may include medical social services provided by a social worker with a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician. Counseling for the patient and caregivers, including dietary counseling is also covered. TRICARE will also pay for home health aide services to include personal care and household services, provided under the supervision of a registered nurse.

There are no deductibles connected with hospice care. TRICARE pays the ***full*** cost of all covered services except for small cost-share amounts, which ***may*** *be collected by the hospice for outpatient drugs and biologicals and inpatient respite care. If the hospice does choose to charge the patient, he or she is responsible for five percent of the cost of outpatient drugs, or $5 on each prescription,*

whichever is less. For inpatient respite care, the patient is responsible for five percent of the amount TRICARE has estimated to be the cost of respite care. These limited cost-share amounts are optional with the hospice.

Reimbursement

TRICARE Standard reimbursement for hospice care is based on national Medicare rates. Hospice programs will receive a single rate for each day of care, based on the type and intensity of services, except for continuous home care where payment is based on the number of hours of care furnished during a 24-hour period. The four pre-determined rates will be based on the following levels of care:

- Routine home care, paid without regard to the volume or intensity of services provided on any given day
- Continuous home care, divided by 24 hours in order to arrive at an hourly rate
- Inpatient respite care, paid for a maximum of five days at a time, including the date of admission but not the date of discharge
- General inpatient care, paid when inpatient care is provided for pain control or acute or chronic symptom management that cannot be managed in other settings

TRICARE will make separate payments for direct patient care services provided by either an independent attending physician or a physician employed by, or under contract with, the hospice program.

Each TRICARE-approved hospice program is subject to a cap on aggregate TRICARE payments from Nov. 1 through Oct. 31 of each year. The cap amount is calculated by multiplying the number of TRICARE beneficiaries electing hospice care during the cap period by the statutory amount determined each year by the Health Care Financing Administration. The aggregate cap amount will be compared with TRICARE payments made during the same cap period. The hospice program must then refund payments in excess of the cap amount.

There is an additional limitation in payments for inpatient hospice care in that the aggregate number of inpatient days, i.e., inpatient and respite care, may not exceed 20 percent of the aggregate total number of days of hospice care provided to all TRICARE beneficiaries during the same period. The TRICARE contractor will multiply the total number of hospice days by .20 to determine the maximum allowable number of inpatient days. If the total number of inpatient days is less than or equal to the maximum, no adjustment will be necessary. However, if the number exceeds the maximum, the hospice program must refund excess payments.

A hospice program may request and obtain a contractor review if there is dissatisfaction with the contractor's calculation and application of its cap amount or inpatient limitation, if the amount in dispute is at least $1,000. There is no further right of appeal beyond the contractor's review.

Unproven Treatments or Procedures

Services and supplies considered to be unproven are excluded from TRICARE coverage. TRICARE welcomes outcome-based Phase III studies, published in refereed medical journals, that show a procedure has been proven safe, effective, and comparable or superior to conventional therapies for the particular diagnosis. TMA will review the literature and determine whether the procedure will remain on the list as unproven.

The TMA Medical Director may consider benefits for rare diseases on a case-by-case basis. A rare disease, according to TRICARE, is one that affects fewer than one in 200,000 Americans. The Medical Director may consult with any or all of the following resources to determine if the proposed benefit is considered safe and effective:

- Trials published in refereed medical literature
- Formal technology assessments
- National medical policy organization positions
- National professional associations
- Regional expert opinion organizations
- Individual and small group expert opinion

TMA adopts the requested benefit if case review indicates the proposed benefit for the rare disease is safe and effective for that disease.

Note: For additional information on unproven procedures, providers should check the Policy Manual on the Web site.

Lithotripsy

TRICARE covers the following lithotripsy techniques for the treatment of kidney stones only:

- Extracorporeal shock wave lithotripsy (ESWL) for use in the treatment of upper urinary tract stones
- Percutaneous lithotripsy, or nephrolithotomy, ultrasound or by the related techniques of electrohydraulic or mechanical lithotripsy
- Transurethral ureteroscopic lithotripsy, or transurethral nephrolithotomy, using either ultrasound, electrohydraulic techniques, or mechanical means

Note: Lithotripsy for the treatment of gallstones is not a TRICARE benefit.

Magnetic Resonance Imaging

MRI, and MRI with or without contrast media, may be covered when medically necessary.

MRIs must be pre-authorized for all patients. If there is a question as to the appropriateness of an MRI or MRI with contrast media, the attending physician will be asked to document the medical necessity.

If it is determined that the less expensive diagnostic procedures could have met the patient's needs, TRICARE Standard will pay no more than the allowance for the less expensive procedure.

Mammograms

TRICARE covers preventive and diagnostic mammograms and office visits related to mammograms. TRICARE has adopted Medicare criteria relating to frequency.

Frequency

TRICARE will not cover screening mammography for an asymptomatic woman under 35 years of age.

For asymptomatic women who are 35 but under 50 years old who are at high risk for breast cancer (e.g., those with a personal history of breast cancer; those with a personal history of biopsy-proven benign breast disease; those whose mother, sister or daughter have had breast cancer; and those who did not give birth before age 30), TRICARE will allow one baseline screening mammogram.

Coverage is limited to the following:

- One baseline mammogram at age 35
- One screening mammogram every 24 months thereafter

For asymptomatic women age 40 but under 50 who are not at high risk for breast cancer, coverage is limited to the following:

- One baseline mammogram at age 40
- One screening mammogram every 24 months thereafter

An asymptomatic woman 50 years old or older is allowed one screening mammogram every 12 months.

In addition, TRICARE will cover charges for a brief or intermediate level office visit associated with the screening service.

In order for TRICARE to share the cost of mammography services, the supplier must be certified by Medicare for participation as a mammography supplier or be certified by the American College of Radiology as having met its mammography supplier standards.

TRICARE will share the cost of the technical component (the radiology technician's charges for performing the service).

TRICARE will also share the cost for a radiologist's interpretation of a physician-requested diagnostic mammogram.

Beyond the charges for the initial office visit, TRICARE will not share the cost of additional or separate charges for the attending or referring physician. The attending or referring physician may not bill for interpretation of a mammogram unless it is within the scope of his or her license.

Maternity Care

Maternity care includes the entire episode of pregnancy, through delivery and up to the first six weeks after the baby is born.

Inpatient Delivery

If the patient lives in the designated ZIP code zone near a military hospital, she must obtain a non-availability statement from that military hospital before receiving any civilian care.

Maternity care that ends in childbirth in or on the way to a hospital is cost-shared on an inpatient basis.

For patients who deliver in TRICARE-approved birthing centers, TRICARE can share the cost on an inpatient basis, even if patients don't stay for 24 hours. A non-availability statement is not required for birthing centers.

A non-availability statement issued for maternity care is good from the time the patient starts prenatal care until 42 days after the delivery. If the newborn remains hospitalized after the mother is released, a separate non-availability statement is not needed unless the hospital stay is longer than 15 days. However, if an active-duty service member gives birth, a non-availability statement is required for newborns on the 4th day.

Beyond this 15-day limit, a valid non-availability statement in the child's name must be obtained.

Outpatient Delivery

If the patient plans to deliver at home and lives in the designated ZIP code zone around a military hospital, she should get a non-availability statement before delivery in case the need for hospital delivery arises.

If the patient has an outpatient delivery, she is responsible for the deductible and corresponding cost-share.

Deliveries in a professional office birthing suite in a physician's office or a certified nurse-midwife's office will be cost-shared as outpatient.

Note: All admissions related to the same maternity episode or birth are considered to be a single admission for cost-sharing purposes, regardless of the number of days between admissions and even when the patient is admitted to more than one hospital.

Maternity and Newborn Care under DRGs

Under the TRICARE Standard DRG-based payment system, separate claims are always required for the mother and the newborn, whether or not the newborn care is considered routine. When the date of birth and the date of admission are the same, the contractor will handle the newborn claim with no cost-share applied to the first three days of the inpatient stay. The contractor will apply the cost-share for any days beyond the first three. If the newborn's claim shows a date of admission different from the date of birth, the cost-share will be applied to all inpatient days.

Providers should bill separately for pregnancy testing and electronic fetal monitoring to avoid confusion and delay in claims processing.

Note: TRICARE does not cover the children of dependent children. Any claim for newborn care of such children will be denied.

Maternity Care Authorized Providers

Generally, hospitals and physicians that provide maternity care are TRICARE-authorized.

Certified nurse midwives may furnish care to TRICARE patients independent of physician referral or supervision. They must be licensed in the area where care is provided, if licensing is offered, and must be certified by the American College of Nurse Midwives.

Note: TRICARE does not cover the services of lay midwives.

Freestanding Birthing Centers

TRICARE shares the cost of maternity care provided by TRICARE-authorized freestanding or institution-affiliated birthing centers that provide a planned course of outpatient prenatal care and outpatient childbirth service limited to low-risk pregnancies. Only natural childbirth procedures are covered.

TRICARE does not require a non-availability statement for birthing center services.

Reimbursement for all-inclusive maternity care and childbirth services furnished by an authorized birthing center is limited to the lower of the TRICARE-established all-inclusive rate or the center's most-favored all-inclusive rate.

Separate charges for educational supplies and prenatal education services, Codes 99071 and 99078, are excluded from coverage.

TRICARE will not share the cost of childbirth service provided by a TRICARE-approved, freestanding ambulatory surgical center unless the surgical center is *also a TRICARE-approved birthing center*.

Questions regarding certification of birthing centers as TRICARE-authorized providers should be directed to the appropriate contractor.

Morbid Obesity

TRICARE covers three surgical procedures for life-threatening overweight conditions: gastric bypass, gastric stapling and gastroplasty, including vertical banded gastroplasty. One of the following conditions must exist for TRICARE to share the cost of these procedures:

1. The patient must be 100 pounds overweight for height and body structure, with a serious medical condition related to morbid obesity, such as:

- Diabetes mellitus
- Hypertension
- Cholecystitis
- Narcolepsy
- Pickwickian syndrome or other severe respiratory disease
- Hypothalamic disorders
- Severe arthritis of the weight-bearing joints

2. The patient is 200 percent or more of ideal body weight for height and body structure, even without a related medical condition.

3. The patient has had an intestinal bypass or other surgery for obesity and requires a second surgery because of complications. The surgeon, in many cases, will do a gastric bypass, gastric stapling or gastroplasty to help the patient avoid regaining the weight that was lost. In this situation, payment is authorized even though the patient's condition may not meet the definition of morbid obesity because of the weight that was already lost following the initial surgery.

TRICARE does *not cover the non-surgical treatment of obesity, to include the gastric balloon and diets*. Services (office visits) and supplies related to obesity and/or weight reduction are specifically excluded from TRICARE. Misrepresentation of the patient's diagnosis or services is considered fraud.

Multiple Surgeries

Multiple surgeries are those procedures performed during the same session. TRICARE makes no distinction between "related" and "unrelated" procedures.

Reimbursement will be the lower of the total billed charges for all procedures performed *or the sum of 100 percent of the allowable charges for the major (higher allowable) surgical procedure plus 50 percent of the allowable charge for all other covered surgical procedures.*

When the surgical procedures involve fingers, toes or excision or biopsies of multiple lesions, reimbursement will be 100 percent of the allowable charge of the **first** procedure, 50 percent of the allowable for the second procedure and 25 percent of the allowable for the third and all subsequent procedures.

No reimbursement will be made for incidental procedures performed during the same operative session where other covered surgical procedures were performed.

Note: See Fraud and Abuse section regarding unbundling.

Pap Smears

TRICARE shares the cost of screening Pap smears and related brief or intermediate office visits for asymptomatic women who are or have been sexually active, or smoke cigarettes, or have reached 18 years of age. Coverage is limited to one annual examination with normal findings for three consecutive years. Thereafter, coverage is limited to one Pap smear every two years. If there is evidence of high risk for cervical cancer, Pap smears will be covered more frequently if documented to be medically necessary and appropriate.

The technical component of performing the test is covered (the laboratory technician's fee). The professional component for the pathologist's interpretation of the test is also covered. The attending or referring physician must not bill for the test interpretation.

The attending physician may not bill for handling the Pap smear in addition to billing for the office visit.

Percutaneous Transluminal Coronary Angioplasty

TRICARE will cost-share for multi-vessel percutaneous transluminal coronary angioplasty (PTCA) for treatment of stenotic lesions in patients for whom the likely alternative is coronary bypass surgery. The patient must have the following characteristics:

- Angina refractory to optimal medical management
- Objective evidence of myocardial ischemia
- Lesions amenable to angioplasty

Standby surgeons for PTCA are not payable, but assistant surgeons are payable.

Penile and Testicular Implants

TRICARE shares the cost of penile implants approved by the Food and Drug Administration (FDA) when the procedure is done for any of the following reasons:

- Organic impotency resulting from disease, trauma or radical surgery
- Correction of a congenital anomaly
- Correction of sex gender confusion

Penile implants for the correction of impotency stemming from psychological or psychiatric causes are not covered.

Testicular prostheses will be cost-shared under the same conditions as listed for penile implants.

Treatment of organic impotency by medication or external appliance approved by the FDA is covered.

Physicians' Assistants

TRICARE shares the cost of care provided by physicians' assistants who are supervised by physicians who employ them and who are themselves authorized providers under TRICARE. The employing physician must bill for the services, but the physician's assistant must be identified on the claim as the actual provider.

For services other than assistant-at-surgery, the allowable charge for physician assistant services will be no more than 85 percent of the allowable charge for comparable services provided by a physician at a similar location. Reimbursement for assistants at surgery may not exceed 65% of the allowable charge for a physician.

Physicians' assistants must meet applicable state requirements and other specific criteria. The appropriate contractor can supply the specific information for those who have questions.

Prescription Drugs and Medicines

Drugs and medicines are allowable for indications by the Food and Drug Administration. Some "off-label" uses are allowed when the scientific literature documents efficacy.

Insulin is covered for diabetic patients, regardless of whether a prescription is required by state law.

Pharmacies are not required to file claims, but the pharmacy *may file claims using the HCFA Form 1500. When the patient files a claim, the bottom half of the claim form must be completed and signed by the pharmacist or a bill must be attached to the claim.*

The following information, which may be a copy of the prescription drug label or an itemized statement from the pharmacist, is required for reimbursement:

- Name of patient
- Name, strength and quantity of each drug
- Prescription number of each drug
- Date prescription was filled
- Cost of each drug
- Name and address of pharmacy
- Name and address of prescribing physician

Certain prescription drug claims must contain the diagnosis or diagnoses, including:

- More than 20 prescriptions on the claim
- More than $250 in drug charges on the claim
- More than $150 in drug charges for any one month
- More than four prescriptions for the same controlled drug in a given month

A copy of the prescription should accompany each claim.

Vitamins are not generally covered under TRICARE. Oral vitamins, even if prescribed for vitamin deficiency or prenatal care, are not a benefit. Vitamin injections may be reimbursable if documentation shows that they are necessary in treating a specific medical condition and the patient cannot take oral vitamins.

TRICARE cannot share the cost for prescriptions written by pharmacists, despite state laws that permit the practice.

Preventive Care

In addition to the immunizations for children up to age six, TRICARE Standard now covers immunizations and comprehensive preventive benefits for eligible beneficiaries age six and above, including health promotion and disease preventive visits provided in connection with immunizations, Pap smears, and mammograms. TRICARE Standard also covers preventive services for colon and prostate cancer examinations.

These preventive services must be provided during the same comprehensive preventive office visit as the associated immunization, Pap smear, mammogram, or colon and prostate exam, or provided as a result of a referral made during that same visit. They include:

- Cancer-screening exams for the following cancers: testicular, skin, oral cavity, pharyngeal and thyroid
- Tuberculosis and rubella antibodies screening (age limits may apply)
- Cardiovascular disease screening (cholesterol and blood pressure)
- Body measurements
- Vision screening
- Counseling services (patient and parent education) for: diet, exercise, cancer surveillance, safe sexual practices, tobacco, alcohol and drugs, dental health, accident and injury prevention, and stress, bereavement and suicide-risk assessment.

Prosthetic Devices

TRICARE covers the purchase of artificial limbs and eyes and items that are surgically inserted into the body as an essential and integral part of an otherwise covered surgical procedure.

Reimbursement

TRICARE Standard pays an allowable charge for professional fees. The CHAMPUS Maximum Allowable charge (CMAC) is the maximum amount TRICARE Standard will pay for medical and other services furnished by physicians and other individual professional providers, medical groups, independent laboratories, suppliers of ambulance services, suppliers of durable medical equipment, medical supplies and prostheses.

Most pricing under the TRICARE program is at Medicare fee scheduled amounts, but some services, such as ambulance and durable medical equipment, are under the allowable charge methodology.

CMAC is adjusted to reflect local economic conditions by using the Medicare Geographic Adjustment Factors. There are 89 different locations throughout the country.

Providers may find more detailed information on the TMA Web site under Systems.

Cost-Share and Deductible

Deductible

The TRICARE Standard beneficiary must pay a deductible for outpatient services ($150 for an individual, $300 for a family) each fiscal year. The fiscal year begins on October 1 and ends on September 30.

The family members of active-duty sponsors whose pay grade is E4 and below continue to pay $50 for an individual and $100 for the family.

If a TRICARE Standard beneficiary has another insurance plan, the deductible for that other plan may also be used as the deductible for TRICARE Standard.

Cost-Share

This is the amount of money for which the TRICARE Standard beneficiary or sponsor is responsible. The patient cost-share is payable to the provider, along with any deductible required for outpatient care. Other health plans use the terms "co-payment" or "co-insurance."

Active-duty families are responsible for payment of the following cost-share:

Outpatient — Twenty percent of the TRICARE-determined allowable charge, in addition to the annual fiscal year deductible.

Inpatient — The amount per day required in a military facility ($10.20 for the 1998 fiscal year) or $25 for each admission, whichever is greater. There is no cost-share applied to professional services associated with the inpatient episode.

Retirees, retiree families, former spouses, and family members of deceased active-duty and deceased retirees are responsible for the following cost-share:

Inpatient and Outpatient Services — Twenty-five percent of the TRICARE-determined allowable charge in addition to the annual fiscal year deductible for outpatient care.

Catastrophic Cap

TRICARE Standard-eligible families are protected from certain catastrophic medical expenses by a limit or "cap" on covered medical bills for care each fiscal year. The limit for active-duty families is $1,000; for all others, the limit is $7,500. The cap applies only to the amount of money required to meet the family's annual deductibles and cost-shares based on TRICARE Standard allowable charges for medical care received in each fiscal year. Cost-shares and deductibles paid under the Program for Persons with Disabilities, charges in excess of the TRICARE Standard allowable charges and charges for non-covered treatment are not subject to the cap.

Providers should be aware that when the cap is reached for care in a fiscal year, TRICARE will reimburse for covered care provided in the remainder of that year at 100% of the TRICARE allowable charge.

Note: In DRG hospitals, the cost-share for beneficiaries who are other than active-duty family members is the lesser of 25 percent of the billed charges or the 1998 fiscal year per diem rate of $360. (This rate may change each year.) Active-duty family members' cost-share is unaffected by DRGs. (See section on DRGs.)

Reimbursement of Technical/Professional Components

TRICARE will share the cost of the technical component on radiology and pathology claims, but the professional component will be cost-shared only if the provider actually renders a service, i.e., as attending physician or consultant.

TRICARE cannot pay a pathologist who merely operates a laboratory, but will reimburse a pathologist who prepares a written lab report for an attending physician, e.g., on a biopsy or frozen section.

Providers who wish to know the prevailing charge for a specific service or procedure may call or write to the TRICARE contractor using the ZIP code where care is given. This information may be found on the Web site under Systems.

Cost-Shares for Hospitals and DRGs

TRICARE Standard uses a diagnosis-related group (DRG) payment system for most admissions to acute-care, short-term hospitals in 49 states, the District of Columbia and Puerto Rico. Maryland is exempt from DRGs.

Hospitals shouldn't attempt to assign a DRG on the claim. The contractors assign DRGs. Claims *must not be submitted by beneficiaries. Hospitals must use the UB-92*.

Mother and newborn charges must be billed separately.

The cost-share provision under DRGs is different for beneficiaries who are *other than active-duty family members. The beneficiary cost-share for these patients is the lesser of the per diem rate ($360 in FY 1998) or 25 percent of the billed charge, not to exceed the DRG amount. Per diem rates are adjusted annually*.

TRICARE Standard's use of DRGs has not affected the way cost-shares are calculated for active-duty dependents who pay $25 for each admission or $10.20 each day (FY 1998), whichever is more.

For exempt hospitals, unless subject to an alternative TRICARE reimbursement system, the cost-share for everyone except active-duty family members will remain the same as it has been in the past, i.e., 25 percent of the allowable charge.

DRG-Exempt Hospitals and Services

- Kidney acquisition costs
- Some transplants (providers should contact the appropriate contractor for information)
- Pediatric cases involving AIDS, cystic fibrosis and bone marrow transplants
- Psychiatric hospitals
- Long-term care hospitals

- Rehabilitation hospitals
- Cancer hospitals
- Sole community hospitals (Medicare-exempt)
- Christian Science sanitoria
- Distinct parts of a hospital providing psychiatric or rehabilitation services

Note: Substance abuse hospitals and substance abuse units of hospitals are no longer exempt from DRGs.

Neonates

There are 32 DRGs for neonates, based on birth weight, operating room procedures and the presence of complications. In paying neonate claims, TRICARE Standard has distinct outlier thresholds that are set so that more cases qualify as outliers, and outlier payment is higher than in non-neonatal cases.

Birth weight is required on all neonatal claims. In all other respects, claims submission is routine.

Exemptions

Professional providers, including nurse anesthetists, employed by hospitals are exempt from DRGs. Hospitals must bill separately for their services, but must participate on these claims. The UB-92 claim form may not be used for billing on these claims. The HCFA Form 1500, shown in Appendix C, must be used. See section on Participation.

Billing

In situations where the DRG-based payment amount is less than the billed amount, the hospital may not bill beneficiaries for the remaining balance after the DRG-based payment amount and the patient's cost-share. The hospital may bill the beneficiary for non-covered items, such as telephones and television.

TRICARE Standard will pay on a lump-sum basis for hospital capital costs and direct medical education costs. Hospitals should contact the appropriate contractor to determine the specific information required for payment of these costs.

TRICARE Standard uses a grouper program similar to Medicare's. There is no uniform price program. DRG weights and rates are routinely published in the *Federal Register*.

Questions about billing practices and claims submission under the DRG payment system should be addressed to the appropriate contractor.

For active-duty family members, no cost-share is taken for professional services rendered in conjunction with the inpatient stay. All others pay 25 percent of the allowable charge for professional services.

Note: See section on Cost-Share for outpatient care.

Participation or Accepting Assignment

Professional Providers

TRICARE Standard encourages providers to participate (accept assignment of benefits). This means that the provider agrees to accept the TRICARE-determined allowable charge as the full fee, even if it is less than the billed amount. TRICARE Standard pays the allowable charge, less the patient cost-share and outpatient deductible. The provider also agrees to make no attempt to charge the beneficiary for more than the allowed amount. However, providers may charge patients for services not covered by the program.

When a provider agrees to accept assignment and then bills the patient for the difference between the amount allowed and the billed charges, he or she violates the agreement and is subject to penalties under TRICARE rules, including withdrawal of program approval as a TRICARE provider and possible recoupment of payments made.

Providers collect the cost-share and deductible from the patient.

Participation facilitates cash flow and ensures payment due *will be made to the provider, rather than to the beneficiary. The contractor processes most claims within 21 days of receipt. When providers participate, they are paid directly*.

Providers may participate on a case-by-case basis. However, TRICARE Standard does encourage families to seek medical care from providers who are willing to participate.

When a provider chooses to participate, “yes” must be checked on the claim form and the provider must sign the form so that payment will be mailed to the provider.

Only participating providers may file appeals (see Appeals) and have a right to information on participating claims.

Non-Participating Providers

Federal law prohibits providers who do not accept assignment from billing TRICARE Standard patients more than 115 percent of the allowable charge for any service. Providers who refuse to comply with the limit could lose their status as authorized TRICARE Standard providers and be subject to other penalties.

Exempted from the billing limitations are: ambulance companies, independent labs, durable medical equipment and medical supply companies, pharmacies, mammography suppliers, and portable x-ray companies. However, effective Jan. 1, 1999, these providers will no longer be exempt from the billing limitation. Providers delivering services on or after that date must comply with the law.

Hospitals

Federal law requires hospitals participating in Medicare to also participate in TRICARE Standard for inpatient services. Hospitals that are subject to the TRICARE Standard DRG payment system, but not Medicare's DRGs, are required to sign participation agreements with TRICARE Standard.

Filing Claims

Professional providers must use the HCFA 1500 form, while institutional providers use the UB-92.

The contractor will send a copy of the Explanation of Benefits (EOB) to the provider, as well as to the beneficiary, even when the beneficiary files the claim. This allows the provider to calculate the 115 percent of the allowable charge for billing purposes.

When participating providers file claims, they will receive payment directly. When providers do not participate, the beneficiary receives payment.

Timely Filing of Claims

Timely filing is essential to good business practice. Claims must be filed within one year from the date a service is provided or within one year from a patient's discharge from an inpatient facility. It is best to file claims as soon as possible.

Claims received after the filing deadline must be denied unless there is sufficient evidence to grant an exception. Some of the exceptions to the deadline are:

- Retroactive eligibility where the uniformed service has made the determination. A copy of the decision must accompany the claim.
- Administrative error on the part of the contractor or the TMA. A statement from the claimant detailing the circumstances and a copy of a letter, report or statement from the TMA or the contractor reflecting the error must accompany the claim.
- Mental incompetence of the patient when no one is legally responsible for managing the affairs of the patient. A physician's statement including diagnosis and treatment attesting to the mental incompetence must accompany the claim.
- Adequate access to care based on procedure code and locality.
- Other health insurance when the patient submitted a claim to a primary health insurance plan and the other plan delayed adjudication past the filing deadline. A statement indicating the original date of submission to the other plan, and date of adjudication by the other plan with any relevant correspondence and an Explanation of Benefits must be submitted. The claim form must be submitted to the TRICARE contractor within 90 days from the date of the other health insurance plan's adjudication.

Proper completion of the claim forms facilitates prompt reimbursement.

Provider Identification Numbers

Professional providers can save time and ensure prompt payment by reporting both the Taxpayer Identification Number (TIN) and the Social Security Number (SSN) on the HCFA 1500.

When a professional provider is part of a clinic, he or she should use the sub-identifier number so the contractor can determine which provider in a clinic actually rendered care.

Claims Filing Jurisdiction

Providers in TRICARE regions should follow the instructions of the appropriate contractor for filing claims.

Generally, claims for medical services should be sent to the contractor that has jurisdiction for the geographic location in which the patient lives.

Double Coverage

When a TRICARE patient also has coverage from another health plan, TRICARE is always the secondary payer. Double coverage rules apply to Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). Medicaid is not considered a double coverage plan, so TRICARE is primary payer in these cases.

When persons who are eligible for Indian Health Service (IHS) care obtain it from a source other than IHS, TRICARE pays first.

Many TRICARE Standard beneficiaries have supplemental insurance policies that pay for their deductibles and cost-shares. In these cases, TRICARE Standard remains primary payer.

Beneficiaries may not waive benefits due from their double coverage plan. If double coverage exists, a claim must be filed with the other plan first. If beneficiaries refuse to claim benefits from the other plan, TRICARE Standard will deny payment.

TRICARE Standard will pay benefits only for charges remaining unpaid after all other health coverage has paid benefits.

The contractors pay the lesser of the amount they would have paid in the absence of other coverage or the difference between the billed (or negotiated) charge and the payment made by the primary insurance.

Some limitations on TRICARE Standard as secondary payer include:

- TRICARE Standard will not pay more as a secondary payer than it would have in the absence of other coverage and will not pay more than the patient liability.
- Benefits cannot be paid for services provided prior to TRICARE eligibility.
- Services must be covered by TRICARE.

TRICARE and HMO Coverage

TRICARE will share the cost of covered care received from an HMO, including the user fees, after the HMO has paid all it is required to pay, under the following conditions:

- The provider must meet TRICARE certification standards.
- The care must be a TRICARE benefit and must be medically necessary.
- If an HMO has a limit on how much it will pay for a service, TRICARE will share the cost of only that portion of the charge the HMO doesn't cover, including emergency services received outside the HMO's service area.
- When services are available through the HMO and a patient chooses to obtain care outside the HMO, TRICARE generally won't pay for the care.

Filing Claims under Double Coverage

When providers who are filing claims are aware that double coverage exists, the provider may annotate the amount paid by the other health insurance on the claim form. On beneficiary-submitted claims, the claim form must be accompanied by evidence of processing by the other health plan, e.g., a copy of the Explanation of Benefits, work-sheet, a letter, or a copy of the pertinent pages from the insurance policy or benefits handbook.

Providers should be aware that TRICARE will not pay for work-related illness or injury that is covered under Worker's Compensation. If the patient fails to apply for Worker's Compensation, TRICARE will not cover the costs of health care. However, TRICARE benefits are available upon evidence that compensation benefits have been exhausted or denied.

The following types of coverage are primary to TRICARE and must pay before TRICARE does:

- Worker's compensation
- Personal injury protection under the patient's own automobile policy
- Coverage under the no-fault or uninsured motorist provisions of the patient's own automobile policy
- Student insurance

In possible third-party liability cases, DD Form 2527 (a third-party liability questionnaire) must be completed and sent to the contractor before a claim is paid. If a claim is sent in and the diagnosis falls in the diagnostic range 800-999 (ICD-9-CM), the contractor will send a DD Form 2527 to the patient. If the form is not returned within 35 days of the contractor's request, the claim and all related claims will be denied. Participating providers may request copies of DD Form 2527 from the contractor.

Note: An unmarried child may be eligible for some other coverage, in addition to TRICARE, through a stepparent. A stepparent's coverage is primary payer even if the other health insurance plan contains a provision stating that the natural parent's coverage is primary.

Adequate Medical Documentation

Before authorizing claims payment, the government is entitled to receive information from providers documenting the services or supplies given to beneficiaries. Providers and beneficiaries who file claims are responsible for supplying all necessary information to the contractor. Failure to furnish requested information could result in denial of the claim.

Providers have certain obligations to furnish services or supplies under TRICARE that are:

- Furnished at the appropriate level and only when and to the extent medically necessary as determined under TRICARE rules
- Of a quality that meets professionally recognized standards of health care
- Supported by adequate medical documentation as may reasonably be required to establish the medical necessity and quality of services furnished, as well as the appropriateness of level of care

If a provider fails to maintain and furnish, upon request, adequate medical documentation, the claim may be denied and there may be sanctions against the provider for potential fraud or abuse.

Adequate medical documentation contains sufficient information to justify the diagnosis, the treatment plan, and the services or supplies furnished. Adequate and sufficient clinical records must be kept by the provider to substantiate that specific care was actually and appropriately furnished; was medically necessary and appropriate; and must identify the individual who provided the care.

Note: Documentation requirements apply to both inpatient and outpatient care.

Medical Documentation and Mental Health Care

TRICARE Standard requires adequate medical documentation for mental health care, including records that provide the means for measuring the type, frequency and duration of active treatment mechanisms used and progress made under the treatment plan. Providers must keep adequate and sufficient records to substantiate that specific care was actually and appropriately furnished, and was medically or psychologically necessary. The provider who actually furnished the care must document the services and may not substitute nursing and staff notes.

Since measuring severity of illness is less exact in the mental health field evaluations, treatment plans, progress notes and discharge summaries are critical to medical review.

Hospital-Employed Professional Providers and DRGs

Hospitals subject to DRGs or the mental health per diem reimbursement system may continue to use the UB-92 claim form to bill for inpatient care, but claims for professional providers who are employed by the hospitals must be submitted on the HCFA Form 1500.

Residents, interns and fellows in teaching hospitals are employees of the hospital. TRICARE cannot make payments to these individuals for their services. The government reimburses medical education costs to hospitals through the DRG payments. The teaching physician may be reimbursed as an attending physician only when he or she personally examines the patient and—

- Reviews the patient's history and the record of examinations and tests in the institution, and makes frequent reviews of the patient's progress; and
- Confirms or revises the diagnosis and determines the course of treatment to be followed; and
- Either performs the physician services required by the patient or supervises the treatment so as to assure that appropriate services are provided by physicians-in-training, and that the care meets a proper quality level; and
- Is present and ready to perform any service normally performed by an attending physician in a non-teaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed; and
- Is personally responsible for the patient's care, at least throughout the period of hospitalization.

Emergency services must be billed separately, since the admission itself triggers the DRG payment.

Hospitals exempt from DRGs or hospitals with exempt units may bill for all services, but all professional services must be billed on the HCFA Form 1500 whether they are billed by the hospital or by the individual providers.

Requests for Additional Information

If the claim form is incomplete or in error, the contractor will either call or write to the provider filing the claim to request additional information.

Prompt, cooperative response from providers will result in speedy processing of claims.

Signature on File

If the provider has an approved "signature-on-file" agreement, the agreement will satisfy the signature requirement for claims submitted to the contractor. The "agreement" may be a patient signature on a form used by the provider in the normal course of doing business. The form must contain the appropriate wording to comply with TRICARE rules and the Privacy Act.

When providers wish to submit claim forms without the patient's signature, they must agree in writing to:

- Verify the patient's eligibility at the time the episode of treatment begins
- Obtain and retain the patient's signature on a provider-designed form. If the patient is under 18 or is incompetent, the signature of a parent or guardian is required. (This is not required if the treatment involves venereal disease or alcohol/drug abuse.)
- Indicate "signature on file" in the patient's signature block on the claim form

TRICARE Standard will conduct random audits of one percent of all claims submitted. Failure to furnish the documented signature-on-file will result in loss of signature-on-file privileges.

Explanation of Benefits (EOB)

For each claim, the contractor issues an explanation of benefits. When the provider files claims, the EOB or payment summary voucher is sent to him or her. The patient always receives a copy of the EOB, even if the provider receives payment. The EOB details the adjudication of the claim. The EOB will also provide information with which the provider can calculate 115 percent of the allowable charge.

The claim identification number assigned by the contractor should be included in any inquiry concerning the payment of the claim.

Reimbursement Problems and Special Services for Providers

Provider Relations

Providers should direct questions concerning benefits and fiscal matters to the contractor for the area where care is given. Providers may direct questions to the TMA–Aurora, with questions about the program, but should approach the contractor first.

The TRICARE contractors employ provider representatives who visit institutions and individual providers on a regular basis. They assist providers with particular problems and disseminate current information. The representatives also conduct special meetings and workshops for providers and their office staffs on a regular basis. Providers who need assistance may contact the appropriate contractor to request a visit or call by these representatives.

Toll-free telephone lines to the contractors are also available to ease contact by providers. In addition, some contractors have provider-dedicated telephone lines.

The TRICARE Management Activity's Public Affairs Office regularly issues news releases to provider media and prepares feature articles for magazines, newsletters and journals that are of interest to providers.

Contractors also distribute news bulletins directly to providers in their regions.

Provider Sanctions

Provider Exclusion and Suspension

A provider is excluded or suspended when he or she is denied status as a TRICARE-authorized provider. This means that the services will not be reimbursed for care rendered to a beneficiary whether the provider or the beneficiary claims the services. Providers shall be denied status based on the following:

- Criminal conviction involving fraud
- Administrative determination of fraud or abuse under TRICARE
- Criminal conviction involving fraud of other federal programs
- Administrative determination that the provider has knowingly participated in a conflict of interest situation
- Administrative determination that it is in the best interests of TRICARE or its beneficiaries to exclude or suspend the provider
- Administrative determination that the provider has been excluded or suspended by another agency of the federal government, a state, or local licensing authority
- Criminal conviction involving fraud of non-federal programs
- Civil fraud involving other programs
- Charging patients more than 115 percent of the allowable charge

Provider Termination

TRICARE contractors and the TMA's Program Integrity Branch have authority to terminate providers as authorized under the program when it is determined that the providers do not meet agency qualifications. Neither the provider nor the beneficiary will be reimbursed for services rendered by an unauthorized provider.

See Appeals section for provider sanction appeal procedures.

Peer Review Organization Program

The quality and utilization review process is governed by 32 Code of Federal Regulations (CFR) 199.15 and Medicare regulations, as referenced in 32 CFR 199.15.

Functions of the Utilization and Quality Review Program

- Assure health services are medically necessary and are provided at the appropriate level

- Assure the completeness, adequacy and quality of care provided
- Improve education of beneficiaries and providers
- Validate diagnoses and procedural information that determines reimbursement in cases where payment is made under the TRICARE Standard DRG system
- Review the necessity and appropriateness of care for which payment is sought on an outlier basis

Provider Responsibilities

As conditions of TRICARE Standard payment, providers are required to:

- Provide a copy of *An Important Message from TRICARE* to every TRICARE Standard beneficiary admitted to their facility
- Provide medical records as requested for both the managed care contractor and for review by the National Quality Monitoring Contractor
- Provide for TRICARE the same physician attestation and physician acknowledgement required for Medicare under 42 CFR 412.40 and 412.46 as a condition for payment, using the same statements as required for Medicare, but substituting "TRICARE" for the word "Medicare."

Recoupment Information

TRICARE contractors make every effort to process claims correctly, but mistakes are sometimes made. When they are, and overpayment results, the government must collect the money that has been spent in error. Some examples of payment errors that require collection are:

- Payment is mistakenly made for someone who is not eligible for TRICARE benefits
- Payment is erroneously issued for care provided by an unauthorized provider under TRICARE
- A provider billed and was paid for medical services that were NOT provided to the patient
- A TRICARE payment was issued for services that are not a TRICARE Standard benefit
- A TRICARE contractor was billed twice and paid twice for the same services

TRICARE is required to collect erroneous payments, regardless of who made the error. Usually, the contractor will ask the party who received the erroneous payment to return it. If the provider received the payment, he or she will be asked to refund it. The letter requesting a refund will include a description of all of the debtor's rights under the law, including the right to appeal. The debtor will also be told of all the actions the government may take to collect the erroneous payment.

When the provider refunds the payment, the patient may be asked to pay the provider for the amount returned to the contractor.

The government may make arrangements with the debtor to make incremental payments if the debt cannot be repaid all at once. If the debtor cannot make payment, he or she will be asked to submit financial data, including income tax returns, statement of retained earnings, profit and loss statements and balance sheets, all of which will be used in determining whether the debt may be compromised or waived. Unpaid debts are subject to penalties and the assessment of interest and collection costs.

If letters requesting refund are ignored, the government may take one or more of the following actions:

- Offset may be taken against future assigned TRICARE Standard claims and the amount offset will be applied to the debt
- If the debtor is retired from the military or federal employment, the retired pay may be offset until the debt is repaid
- The debtor's federal income tax refund may be withheld and applied to the indebtedness
- The debt may be referred to a credit bureau, affecting future credit

Legal action may be taken against the debtor. A court judgment against the debtor may result in a seizure of assets to satisfy the debt.

Under the peer review process, when services or items are deemed not medically necessary, the beneficiary may not be held liable. The provider must refund to the patient any amount excluded from payment if:

- The patient didn't know and could not reasonably have been expected to know that the services were excludable by reason of being not medically necessary; and
- The provider knew or could reasonably have been expected to know that the services were excludable by reason of being not medically necessary.

Note: For additional information on liability, see section on Appeals.

Transplants

The contractor's medical director or some other designated person has authorization responsibility for transplantation.

Heart Transplants

TRICARE Standard shares the cost of heart transplants for beneficiaries with end-stage cardiac disease when the procedure is performed at a TRICARE- or Medicare-approved heart transplant center.

Providers who have questions about heart transplant coverage or who want to request TRICARE Standard approval of heart transplantation centers should contact the appropriate contractor.

Heart-Lung and Lung Transplants

Heart-lung and single or double lung transplants are covered for patients with end-stage pulmonary or cardiac disease when more conventional therapies have failed. Patient selection must be based on critical medical need and maximum likelihood of successful clinical outcome, including full rehabilitation, following transplantation.

Selected patients must not have other medical conditions or adverse factors that would jeopardize successful transplantation. In addition, transplant facilities must meet TRICARE criteria, which focus on survival rates and experience of teams. In order for TRICARE to share these transplant costs, the patient must have received pre-authorization, and the procedure must be performed in a TRICARE-certified facility.

Note: TRICARE cannot share the cost of transplants paid through a research grant or funding.

TRICARE Standard patients need pre-authorization from the contractor's medical director.

Liver Transplants

Pre-authorization by the contractor is required, in addition to the non-availability statement. The transplants must be performed at approved centers (TRICARE or Medicare).

Patients must be suffering from end-stage hepatic disease and be approaching the terminal stage of their illness. More conservative treatment must have first failed.

Liver-Kidney Transplants

TRICARE will cover combined liver-kidney transplantation for patients with end-stage liver and renal disease, when more conservative therapies have failed. Patients must not have other medical problems, in addition to hepatorenal failure, that would jeopardize successful transplantation.

Under TRICARE, pre-authorization is done by the Managed Care Support contractor's medical director or other designated staff.

Living-Related Donor Liver Transplants

TRICARE Standard will share the cost of living-related donor liver transplants for patients who meet selection criteria.

Pre-authorization authority lies with the contractor's medical director, the health care finder or other designated staff.

All liver transplant procedures must be performed at TRICARE Standard- or Medicare-approved liver transplantation centers.

TRICARE cannot share the cost of any transplantation paid for by research funds, nor for any medications that have not been given Food and Drug Administration approval.

Note: Pancreatic transplantation, either alone or in conjunction with any other organ, is considered an unproven procedure, i.e., not reimbursable by TRICARE.

Program for Persons with Disabilities

The TRICARE Standard Program for Persons with Disabilities exists for active-duty family members who cannot get disability-related services or items through public resources. TRICARE cannot share the cost of care under the program when adequate public resources are available to the spouse or child of an active-duty service member. Claims will be denied if program criteria are not met.

Other TRICARE Standard beneficiaries (retirees, spouses and children of retirees, and spouses and children of deceased active-duty members or deceased retirees) do not qualify.

TRICARE requires evidence that services or items are not available from a publicly funded source. A public official or a military treatment facility commander must provide a written statement indicating that no adequate public facilities are available and that no public funds are available to pay any portion of the cost of care. A public official's statement is valid for one year from the date it is issued.

Active-duty family members who are moderately or severely mentally retarded or who have serious physical disabilities may qualify for the Program for Persons with Disabilities.

Benefits under the Program for Persons with Disabilities cover the following general areas:

- Diagnostic and treatment services
- Equipment
- Institutional care
- Prosthetic devices and orthopedic appliances
- Training and special education
- Transportation related to services

Providers should be aware that benefits under the program are subject to the specific limitations of TRICARE. The TRICARE contractor must authorize any services or items before they are received. Families should send a request for benefits to the appropriate contractor for their state. A change of physicians or facilities requires a new request.

The attending physician must establish that the beneficiary meets the clinical eligibility requirements for the Program for Persons with Disabilities and the need for the requested services or items. Copies of relevant text or examination reports should be included to support clinical conclusions.

Payments for all services under the program are limited to $1,000 per month for one individual within a family, with no limit for additional family members. If the cost of care exceeds this amount, the patient's family must make up the difference. There is also a monthly cost-share based on the sponsor's pay grade.

TRICARE Standard Mental Health Benefits

TRICARE covers the cost of certain mental health care for those patients who suffer from mental disorders that involve a clinically significant behavioral or psychological pattern—one that not only causes distress, but actually impairs the ability to function appropriately for their age. The psychological disorder must also be listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) of the American Psychiatric Association.

TRICARE Standard has a program to certify the medical necessity of mental health care for TRICARE Standard beneficiaries. Under TRICARE, the contractor for the region is responsible for certifying medical necessity of care.

Pre-authorization of all admissions, including to DRG facilities and residential treatment centers, is mandatory. Contractor staff who are clinically qualified and trained in utilization management will assess medical necessity and level of care, using mental health review criteria.

Services Requiring Authorization

Inpatient Care Requiring Authorization

- All hospital admissions
- Admissions to psychiatric partial hospitalization programs
- 30- or 45-day waiver requests and waivers of the 150-day limit for residential treatment center (RTC) care, regardless of when the limit was reached
- Inpatient psychotherapy that exceeds five sessions per week
- RTC admissions for children and adolescents
- Special institutional provider (SIP) admissions for drug and alcohol abuse, including partial hospitalization

Outpatient Care Requiring Authorization

- Psychotherapy services beyond eight visits
- Psychotherapy services that exceed two sessions in a week
- Psychoanalysis

Emergency Admissions

TRICARE Standard requires that the contractor be contacted within 72 hours to authorize emergency admissions. An emergency exists when the patient is an immediate risk to self or others and actually has the intent, plan and opportunity to carry out destructive action. The attending physician or authorized provider with admitting privileges at the facility must actually see and evaluate the patient and attempt crisis intervention prior to admission.

Services for which payment is disallowed for failure to obtain pre-authorization may not be billed to the patient or the patient's family.

Certification does *not* guarantee payment, but it does certify that the treatment is medically necessary and delivered at the appropriate level according to TRICARE Standard rules and definitions. The TRICARE contractors continue to be responsible for determining a patient's eligibility and some benefit limits as well as assuring that claims filing requirements are met.

Non-Availability Statements

Pre-authorization does not eliminate the need for a non-availability statement when the patient lives within the ZIP code service area around a military hospital.

Patient Liability

The following Waiver of Liability provision applies to all mental health care that is denied on a retrospective basis because the care was not medically necessary:

- The patient may not be billed for any denied services provided prior to the day following the patient's receipt of the written denial by the contractor, which is presumed to be five days after the date of the notice; or
- The day following the patient's signing a statement from the provider that specifically describes the services that will not be reimbursed by TRICARE and the patient agrees, in writing, to pay for the non-TRICARE Standard reimbursable services. General statements, such as those signed at the time of admission, do not qualify.

Economic Interest

Providers who have an economic interest in a facility may not be reimbursed when they admit a patient to the facility unless a waiver of this rule is granted. Providers must inform the contractor that they have an economic interest in the facility when pre-authorization is requested and, if

appropriate, the waiver will be granted at that time. However, if providers fail to give notice of economic interest, they are subject to revocation of their status as TRICARE-authorized providers.

Outpatient Care

For outpatient care, TRICARE Standard will share the cost for a maximum of one outpatient psychotherapy session a day (one hour of individual therapy or 90 minutes of group therapy), up to two sessions in a seven-day period, unless more are justified as medically or psychologically necessary. This certification must accompany the claim.

Crisis intervention allows for coverage up to two hours in a day when determined to be medically necessary.

TRICARE Standard covers collateral visits, both inpatient and outpatient, that are medically or psychologically necessary for the patient's treatment. A collateral visit is defined as a session between an authorized, individual professional provider and a significant person in the patient's life, but *not* treatment. The significant person may be someone other than a relative.

A collateral visit is counted as a session of psychotherapy.

Inpatient Care (Limits)

Note: Federal law restricts the use of TRICARE Standard funds for inpatient mental health care to a maximum of 30 days in any fiscal year or episode of care for adults aged 19 or older, and 45 days for patients under age 19, unless a waiver is granted. The limitation on inpatient care in a TRICARE-certified residential treatment facility is 150 days in any fiscal year or episode of care. This limitation does not apply to the Program for Persons with Disabilities.

Note: TRICARE Standard partial hospitalization rules are addressed below.

The age of the patient at the admission date determines the number of days allowed. If the care is in a hospital, TRICARE Standard will cover a maximum of five psychotherapy sessions in a seven-day period, or more, if medically necessary and pre-authorized.

Note: Care in multiple facilities is still subject to the limits. Substance detoxification and rehabilitation days continue to count toward the statutory limits.

The appropriate contractor for substance abuse may grant waivers to these limitations.

For details on how to apply for waivers, call the appropriate contractor.

Providers may not appeal the denial of claims for inpatient care that exceeds day limits, but they may appeal a denial of a request for a waiver.

Substance Use Disorder Limits

TRICARE coverage is limited to three substance use disorder treatment benefits in a lifetime, unless the limit is waived. A benefit period begins with the first date of covered treatment and ends 365

days later, regardless of the total services actually used within the benefit period. Unused benefits cannot be carried over to a subsequent benefit period.

Rehabilitative care in a single benefit period is limited to no more than one inpatient stay in hospitals subject to the DRG-based payment or 21 days in a DRG-exempt facility, unless the limit is waived.

Providers should check with the appropriate contractor for limits on detoxification and documentation of medical necessity.

Timeliness of Requests for Reconsideration

Providers who wish to request a reconsideration must submit a written request within 90 days of the date on the written initial determination. If the contractor receives a request after 90 days, it will be denied.

Expedited Reconsiderations

Providers should contact the appropriate contractor or the National Quality Monitoring Contractor for information on expedited reconsiderations when the beneficiary is in an inpatient facility. KePro, the contractor who performs the quality monitoring, may be reached at (717) 561-4953.

Documentation

Providers seeking reconsiderations should document the clinical rationale for their treatment decisions. This documentation should include specific references to the medical record giving evidence of the symptoms and behavior supporting their decisions. A copy of the medical record should be included, as well. The contractor will process fully documented reconsideration requests more quickly.

The reconsideration decision is final for providers with one exception. The TMA accepts a provider's request for a hearing only if the provider is appealing the fact that he or she could not have known that the services in question would not be TRICARE Standard benefits and, therefore, should not be financially liable. Since pre-authorization is available, this shouldn't happen very often.

Mental Health Providers

All psychiatric hospitals, in order to be TRICARE-approved, must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Hospitals may be granted interim approval if they have not been in operation long enough for JCAHO accreditation, but they must have Medicare approval.

TRICARE Standard uses a per diem payment method, based on patient volume and hospital charges, for inpatient mental health care in all specialty psychiatric hospitals and psychiatric units

that are exempt from the TRICARE Standard diagnosis-related group (DRG) payment system. The payment system covers mental health care in all 50 states, the District of Columbia and Puerto Rico.

TRICARE Standard pays a predetermined rate for each day of care provided. For high-volume hospitals (25 or more TRICARE discharges in a federal fiscal year), daily rates are hospital-specific, reflecting average, allowed daily charges. For low-volume hospitals and units (those with fewer than 25 TRICARE discharges in a federal fiscal year), daily rates are based on the hospital's federal census region and calculated on the basis of claims paid during the base period.

Rates are updated each year, based on Medicare's update factor for its Prospective Payment System-exempt facilities.

Questions about the mental health daily rates should be addressed to the appropriate contractor.

Residential Treatment Centers

TRICARE Standard shares the cost of care in residential treatment centers (RTCs) that are separate institutions or distinct units of institutions. These facilities exist specifically for 24-hour, psychiatric treatment of children and adolescents.

The RTC must be organized and professionally staffed by TRICARE-authorized mental health professionals to provide residential treatment of mental disorders to children and adolescents up to age 21 who have sufficient intellectual potential to respond to active treatment.

Under federal law, RTC care may not exceed 150 days in a fiscal year or in any episode. Waivers may be requested from the appropriate contractor.

Some important things to remember about RTC care include:

- The patient must be suffering from a mental disorder that involves a clinically significant behavioral or psychological pattern—one that not only causes distress but also actually impairs the patient's ability to function.
- The disorder must be one listed in the Diagnostic and Statistical Manual (DSM-IV) of the American Psychiatric Association.
- A psychiatrist or a doctor of clinical psychology must direct development of the treatment plan.
- Inpatient treatment must be required, i.e., outpatient treatment would not be appropriate.
- A 24-hour-per-day protected and structured environment must be medically or psychologically necessary.

TRICARE will not share the cost of any care ordered by a court unless the care would have been medically or psychologically necessary, even if the court had not ordered it and the family is legally responsible for paying for the care.

TRICARE may not pay for RTC care that has not been certified by the contractor.

RTCs must be accredited by the JCAHO under the Behavioral Health Manual. RTCs must submit an application for authorization.

Provider Certification of RTCs

The Colorado Foundation for Medical Care handles provider certification for RTCs, partial hospitalization programs and facilities providing treatment for substance use disorders. Administrators should send all written inquiries and applications for TRICARE certification to:

CFMC
P.O. Box 17300
Denver, CO 80217-0300

RTCs must sign participation agreements with TRICARE to be authorized providers. TRICARE Standard cannot share the cost of any care provided before the date the participation agreement is signed by the TMA or a designee. The agreement requires the RTC to accept the TRICARE Standard determined rate as payment in full and collect from the beneficiary or his/her family only the beneficiary cost-share and non-covered charges, e.g., education. Participation agreements include the specific rate established for each RTC and the billing number that must be used for claims filing.

The daily rates are all-inclusive and are established based upon data provided by each RTC. The per diem rate includes the RTC's daily charge for all inpatient care and all mental health treatment determined necessary and rendered as part of the patient's treatment plan authorized by the mental health review contractor.

The per diem rate includes all individual and group therapy, family therapy for parents within 250 miles of the facility, collateral visits with others, ancillary services and drugs.

The only allowed charges outside the all-inclusive rate are for:

- Geographically distant family therapy, i.e., more than 250 miles from the facility
- Educational services when local or state agencies refuse to pay for them and TRICARE payment is pre-authorized
- Medical services unrelated to mental health

TRICARE will not share the cost of services rendered by independent mental health providers to RTC patients. These providers must look to the RTC for their payment.

Partial Hospitalization

TRICARE covers partial hospitalization for psychiatric disorders as well as alcohol and drug use rehabilitation. The benefit is limited to 60 days of treatment in each fiscal year, with waivers available for unusual cases. (Partial hospitalization for treatment is limited to 21 days in each fiscal year.) Services may be provided on a full-day (six hours or more) or half-day (three to six hours) basis. TRICARE Standard will not pay for a program of less than three hours each day.

Pre-admission and continued-stay authorizations are required for all care in a partial hospitalization program. The contractor will review and authorize all care before admission and during the episode of care.

Partial hospitalization facilities may be freestanding or hospital-based. They must be certified by the contractor and enter into a participation agreement before admitting TRICARE Standard patients.

Reimbursement will be based on fixed regional per diem rates that include patient assessment, psychological testing and assessment, treatment services, board and ancillary services. Individual and family psychotherapy, up to five sessions each week, may be billed separately when they are provided by TRICARE-authorized providers who are not employed by or under contract with the facility. Services that are not normally included in the evaluation and assessment of the patient may also be billed separately.

Claims for professional services must include a statement that the psychotherapy is related to a partial hospitalization stay.

TRICARE shares the cost of partial hospitalization and associated psychotherapy as inpatient care.

Professional Providers

Psychiatrists must be Doctors of Medicine or Doctors of Osteopathy and be licensed in the jurisdiction where care is provided.

Clinical psychologists must be licensed for independent practice in the state where services are provided and:

- Have a doctoral degree in psychology from a regionally accredited university and a minimum of two years of supervised clinical experience in psychological health services, of which at least one year is post-doctoral and one year is in an organized psychological health service training program; or
- Be listed in the National Register of Health Service Providers in Psychology, published by the Council for the National Register of Health Service Providers in Psychology.

Clinical social workers must:

- Be licensed or certified at the master's level as clinical social workers by the state where care is provided;

  Note: For the states of New Jersey, Indiana and Wisconsin, TRICARE Standard will accept ACSW-level certification in the National Association of Social Workers or the diplomats status granted by the American Board of Examiners in Clinical Social Work.

- Have a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education; and

- Have a minimum of two years or 3,000 hours of post-master's degree clinical social work practice under the supervision of a master's degree level social worker in an accredited hospital, a mental health center, or other appropriate clinical setting.

Certified clinical social workers may provide covered services independent of physician referral and supervision.

Note: When a patient has an organic medical problem, a physician must concurrently manage the patient's care.

Certified psychiatric nurse specialists must:

- Be licensed registered nurses; and
- Have at least a master's degree in nursing with a specialization in psychiatric and mental health nursing; and
- Have at least two years of post-master's degree practice in the field of psychiatric and mental health nursing, including an average of eight hours of direct patient contact per week; or
- Be listed in a TRICARE-recognized, professionally sanctioned listing of clinical specialists in psychiatric and mental health nursing.

Certified psychiatric nurse specialists may provide covered care independent of physician referral and supervision.

Marriage, Family and Pastoral Counselors

Marriage and Family Therapists

TRICARE Standard rules no longer require physician referral and coordination with certified marriage and family therapists who have entered into an agreement to participate (accept assignment).

While marriage and family counseling is not covered under TRICARE Standard rules, TRICARE will help pay for psychotherapy by individuals who fall in the general category of marriage and family therapists. Patients must be receiving psychotherapy for a valid mental disorder listed in DSM-IV.

All referrals are subject to the utilization contractor's quality-assurance procedures under TRICARE Standard rules. Reviews take place every eighth session.

The educational and experience requirements for counselors are:

- A recognized graduate professional education with the minimum of an earned master's degree from an accredited educational institution in an appropriate behavioral science field or mental health discipline; and

- 200 hours of approved supervision in the practice of either marriage and family counseling or pastoral counseling, ordinarily to be completed in a two- to-three-year period. At least 100 hours must be in individual supervision. TRICARE prefers that the experience be with more than one supervisor and include a continuous process of supervision with at least three cases; and
- 1,000 hours of clinical experience in the practice of marriage and family counseling or pastoral counseling under approved supervision, involving at least 50 different cases; or
- 150 hours of approved supervision of the practice of psychotherapy, ordinarily to be completed in a two- to-three-year period, of which at least 50 hours must be individual supervision; plus, at least 50 hours of approved individual supervision of the practice of marriage and family counseling, ordinarily to be completed within a period of not less than one or more than two years; and
- 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus, at least 250 hours of clinical practice of marriage and family counseling under approved supervision, involving at least 20 cases; and
- Possession of a valid state license or certificate as a marriage and family counselor or pastoral counselor, or hold a license or certificate that allows the individual to provide marriage and family counseling in states that require such licensing or certification; even if licensing is voluntary, TRICARE requires licensing for reimbursement.

In those states that do not offer licensure, the marriage and family therapist must, in addition to meeting the other requirements listed in this section, be a full clinical member of the American Association of Marriage and Family Therapy (AAMFT) or submit documentation from the AAMFT proving eligibility.

Certified marriage and family therapists must agree to accept the TRICARE-determined allowable charge as payment in full, except for applicable deductibles and cost-shares. In addition, these providers must hold patients harmless for non-covered care.

Note: When a patient has organic medical problems, a physician must concurrently manage the patient's care.

Pastoral Counselors

Pastoral counselors must meet the same educational and training requirements required of marriage and family therapists. TRICARE requires that they be licensed to practice by their jurisdiction as pastoral, mental health or professional counselors. In jurisdictions where licensure or certification is not offered, the pastoral counselor must be either a fellow or diplomats member in the American Association of Pastoral Counselors (AAPC) or submit documentation from the AAPC proving eligibility.

Pastoral affiliates, professional affiliates or pastoral counselors-in-training are not eligible for consideration as TRICARE-authorized pastoral counselors.

In order for TRICARE Standard to share the cost of care by a pastoral counselor, a physician must refer the patient for therapy and the physician must provide ongoing oversight and supervision of the therapy. In addition, the pastoral counselor must certify on each claim that a written communication has been made or will be made to the referring physician of the results of the treatment.

A pastoral counselor may elect to be authorized under TRICARE as a certified marriage and family therapist, subject to the same requirements of accepting assignment or participating and signing an agreement with the TMA. The patient will be held harmless for non-covered services.

Note: TRICARE will not recognize dual status for pastoral counselors. They must choose to be authorized as pastoral counselors or marriage and family therapists.

Mental Health Counselors

TRICARE shares the cost of covered psychotherapy provided by mental health counselors who meet requirements. Mental health counselors may provide psychotherapy for patients who have a medically diagnosed mental disorder, subject to the referral and supervision of a physician.

The appropriate utilization review contractor will review all outpatient mental health services at least every 24 sessions in a calendar year.

The appropriate contractor is responsible for certifying mental health counselors as authorized TRICARE providers.

The educational and experience requirements for mental health counselors are:

- A master's degree in mental health counseling or an allied mental health field from a regionally accredited institution; and
- Two years of post-master's experience that includes 3,000 hours of clinical work and 100 hours of face-to-face supervision; and
- A state license or certificate to practice as a mental health counselor; if the state does not offer licensure, the counselor must be certified by, or be eligible for, membership in the National Board of Certified Counselors (NBCC)

Membership in the NBCC may be verified by checking the association's register or by calling the association at (910) 547-0607.

Physician Referral and Supervision

TRICARE requires physician referral and supervision of pastoral and mental health counselors.

The requirements are:

- The physician must refer a patient to a pastoral or mental health counselor for the treatment of a medically diagnosed condition. The physician must actually see the patient, do an evaluation and arrive at an initial diagnostic impression prior to referral. Documentation of the

examination, diagnostic impression and referral must be submitted with the initial claim for services.

- The referring physician must provide oversight and supervision of the episode of treatment. Overall case management rests with the physician. The pastoral or mental health counselor must maintain ongoing coordination with the physician and certify on each claim that written coordination has been made or will be made to the referring physician at the end of the treatment, or more frequently, as the physician requires.

Psychiatric Emergencies

Normally, psychiatric admissions do not qualify as emergencies under TRICARE rules. Exceptional cases, in order to qualify as emergencies, must meet all of the following criteria:

- The medical record must clearly justify that the patient was, at the time of admission, at immediate risk of serious harm to self or others. The admitting physician or other qualified mental health professional with hospital admission authority must do a psychiatric evaluation before the admission. The medical record must include the patient's immediate intent to commit harm and the plan, method and opportunity to carry out the intended harm.
- Medical documentation must show that the patient requires immediate and continuous skilled observation and treatment at the acute psychiatric level of care.
- The medical record must document an unsuccessful attempt at crisis intervention prior to admission.

Note: Providers must contact the appropriate contractor within 72 hours of an emergency admission.

Substance Use Disorder Rehabilitation Facilities (SUDRFs)

Rehabilitation facilities providing care for patients who suffer from substance use disorders must be accredited by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) under the Behavioral Health Manual or the Commission on Accreditation of Rehabilitation Facilities (CARF). The facilities may be either freestanding or hospital-based, but must be operating primarily for the purpose of providing treatment of substance use disorders, either inpatient, partial or outpatient care. Facilities must meet TRICARE standards for SUDRFs and sign participation agreements.

Treatment of Substance Use Disorders

TRICARE covers SUDRFs, whether they are hospital-based or freestanding. (See standards above.)

Providers should contact the contractor before admission to obtain pre-certification for inpatient detoxification, rehabilitation treatment, and partial hospitalization for alcohol and drug abuse.

For both inpatient care and partial hospitalization, TRICARE Standard does not cover more than 21 days, unless a waiver is granted.

TRICARE rules limit rehabilitation to three lifetime episodes. A benefit period begins with the first date of TRICARE-covered treatment and ends 365 days later, whether or not other benefits are actually used later during the year. Unused benefits cannot be carried over to the next period.

Patients may receive any or all of the following services during a benefit period:

- Detoxification in an authorized center limited to seven days per episode.
- There is no lifetime limit on the number of admissions for detoxification.
- Hospital detoxification will be covered only if medical review affirms that hospital-level care is medically necessary. Benefits are paid the same as for any medically necessary inpatient care. Hospital detoxification is not covered beyond seven days, unless medical review affirms that more is medically necessary.
- Rehabilitation on a residential or part-time (day or night program) basis, not beyond 21 days.
- Outpatient care in an authorized treatment center, not beyond 60 visits; and
- Family therapy, not beyond 15 visits.

TRICARE will share the cost of prescriptions for Disulfiram (Antabuse). However, TRICARE will not cover hospital bills if the patient is admitted only to receive Disulfiram.

The following are not covered under TRICARE Standard:

- Halfway houses.
- Academic, vocational or other counseling that is not medically or psychologically necessary. The services of alcoholism counselors are covered as part of alcohol rehabilitation, but must be billed for by the authorized alcohol treatment center and included in the facility's TRICARE-determined allowable cost rate.
- Aversion therapy using drugs or other physical means. This is currently considered unproven under TRICARE rules.
- Any substance use disorder inpatient treatment, including detoxification, counts toward the 30- or 45-day inpatient psychiatric limit. All DSM-IV diagnoses, including drug abuse treatment, involving inpatient care count toward the limit.
- Partial hospitalization does not count toward the inpatient day limit.

Special Considerations

Pervasive developmental disorders, as defined by DSM-IV, and attention deficit disorders are covered. Specific developmental disorders, e.g., dyslexia, developmental arithmetic disorders,

developmental language disorders, developmental articulation disorders and mixed disorders, are not covered. Special education of any type is excluded.

Services that are medically or psychologically necessary to diagnose or treat attention deficit disorders are covered when rendered by TRICARE-authorized providers. Such services include:

- Diagnostic testing and assessment, including neurological evaluation
- Medication
- Psychotherapy, particularly behavioral and family therapy

Chemotherapy management is covered only as an independent procedure and is considered as part of the allowable charge if provided by the same individual who is providing psychotherapy. Charges are not payable if the provider billing for such services is not qualified by state licensure to prescribe psychotropic drugs.

Electroconvulsive therapy is covered.

Excluded Services

Psychosurgery is not covered. Surgery for the relief of movement disorders, electroshock treatments and surgery to interrupt the transmission of pain along sensory pathways are not considered psychosurgery.

Mental health services and supplies related solely to obesity and/or weight reduction are not TRICARE benefits.

The following therapies and procedures are not TRICARE benefits:

- Environmental ecological treatments
- Megavitamin or orthomolecular therapy
- Transcendental meditation
- Rolfing
- Z therapy
- EST
- Primal therapy
- Bioenergetic therapy
- Carbon dioxide therapy
- Guided imagery
- Sedative action electrostimulation therapy

- Aversion therapy (includes electric shock and the use of chemicals for alcoholism)
- Narcotherapy with LSD
- Marathon therapy
- Hemodialysis for schizophrenia
- Training analysis
- Filial therapy
- Sexual dysfunction

In addition, TRICARE does not cover personality enhancement sessions, such as assertiveness training, or any therapy that is given as part of an educational program.

Eating Disorders

TRICARE covers some treatment for so-called "eating disorders," but the diagnosis must be one of the following DSM-IV disorders:

- Anorexia nervosa
- Bulimia
- Pica
- Rumination disorder of infancy
- Atypical eating disorder

TRICARE does not cover freestanding "eating disorder programs." In addition, TRICARE will not pay for services provided by a health professional who is employed by, or is under contract to, a freestanding eating disorder program.

TRICARE may, however, share the cost of individual services and supplies that are medically necessary and appropriate treatment of an eating disorder provided by hospitals, or by psychiatrists, psychologists, clinical social workers or psychiatric nurse practitioners, or otherwise TRICARE-authorized providers.

If a TRICARE authorized institution provides otherwise covered care within the context of an eating-disorder program, claims will not be denied solely because the service was provided in a treatment program.

TRICARE contractors will adjudicate all eating disorder claims as mental health claims, subject to pre-authorization. This includes all inpatient claims and selected outpatient treatment claims.

Weight-reduction programs are not covered. (See section on Morbid Obesity.)

Appendix A
Glossary

Accepting Assignment

A provider who accepts TRICARE Standard assignment (participates) agrees to accept the allowable charge as the full fee and cannot charge the patient the difference between the provider's charge and the allowable charge.

Active-Duty Service Member

A person who is serving full-time in a uniformed service under orders for 30 days or more.

Adjunctive Dental Care

Dental care that is medically necessary for the treatment of an otherwise covered medical and not dental condition, e.g., intraoral abscesses, cellulitis, loss of jaw substance.

Allowable Charge

The TRICARE-determined level of payment to physicians and other individual professional providers. It is the lower of the billed charge or the maximum allowable charge.

Attending Physician

One who has primary responsibility for the medical diagnosis and treatment of the patient.

Authorized Provider

A hospital, institution, physician or another professional who meets the licensing and certification requirements of TRICARE and is practicing within the scope of that license.

Beneficiary

A person who is eligible for TRICARE (formerly called CHAMPUS) or CHAMPVA.

CHAMPUS

The Civilian Health and Medical Program of the Uniformed Services. The program is now called TRICARE Standard.

CHAMPUS Maximum Allowable Charge

The most TRICARE Standard will allow for a procedure or service. It includes the government's share and the patient's share of the cost.

CHAMPVA

The Civilian Health and Medical Program of the Veterans Administration.

Contractor

The company that provides for health care delivery and managed-care support services in various TRICARE regions.

Cooperative Care

A program that supplements the military medical system when the military facility does not release the medical management of the patient to a civilian provider.

Coordination of Benefits

The coordination of the payment of TRICARE benefits with the payment of benefits made by the double coverage plan so that there is no duplication of benefits paid between the double coverage plan and TRICARE.

Cost-Share

The patient's share of the cost for authorized care, depending on the sponsor's military status.

Custodial Care

Care that primarily supports and maintains the patient's condition without active or aggressive medical treatment. The patient is mentally or physically disabled, and the disability is expected to continue and be prolonged.

DEERS

The Defense Enrollment Eligibility Reporting System, a database used to verify beneficiary eligibility.

Dependent

Any spouse or child of an active-duty, retired or deceased active-duty or retired person of the uniformed services.

DME

Durable medical equipment that costs more than $100, withstands repeated use, improves function or retards any further deterioration of a physical condition, and primarily provides a medical function and not simply transportation.

Double Coverage

The patient also has entitlement to insurance, medical service, health and medical plan, or other government program through employment, law, membership in an organization or as a student (including entitlement by reason of being retired from an organization or group), which in whole or in part duplicates TRICARE benefits. This does not include entitlement to receive care from the Uniformed Services Medical Care System.

EOB

Explanation of benefits. A statement issued by the contractor explaining how a claim was handled, e.g., what was paid.

Fiscal Year

The federal government's twelve-month accounting period running from October 1 to September 30 of the following year.

HBA

Health benefits advisor. Military bases employ HBAs to help beneficiaries with questions about benefits and claims filing.

Health Care Finder

TRICARE contractors employ health care professionals who assist beneficiaries in TRICARE regions with locating providers and in getting prior authorization for certain types of procedures and hospitalization. They are available at TRICARE Service Centers in TRICARE areas, seven days a week, 24 hours a day.

ID Cards

Cards issued by the uniformed services and the Department of Veterans Affairs showing a person is eligible for TRICARE or CHAMPVA and other benefits.

Judge Advocate

The legal officer at a military base who is responsible for collecting TRICARE money in third-party liability cases, e.g., auto accident liability insurance payments.

Maternity Care

The total episode of pregnancy, including all prenatal, delivery and postnatal care at six weeks and two days; also includes treatment of complications.

Medically Necessary

The frequency, extent and types of services or supplies that represent appropriate medical care and are generally accepted by qualified professionals as reasonable and adequate for the diagnosis and treatment of illness, injury, or maternity and well-baby care.

National Quality Monitoring Contractor

KePro is the current quality monitoring contractor. Providers may reach KePro's office at (717) 561-4953.

Non-Availability Statement

Statement issued by a uniformed services hospital when medical care can't be provided there and the patient must use civilian care. Patients who live outside the designated ZIP code zone surrounding the service hospital do not need a non-availability statement.

Non-Participating Provider

One who decides not to accept the TRICARE-determined allowable charge as the full fee for care. Payment goes directly to the patient in this case, and the patient must pay the bill in full.

Providers are limited to charging 115 percent of the TRICARE allowable charge. Non-participating providers must file claims unless the patient has other primary health insurance. Pharmacy claims and claims for certain retail items are excepted.

Participating Provider

One who accepts TRICARE Standard assignment (see Accepting Assignment). Payment in this case goes directly to the provider. The patient must still pay the cost-share, outpatient deductible and the cost of care not covered by TRICARE Standard.

Provider

Person or institution rendering medical services to the patient.

Recoupment

A formal request for refund of money paid by TRICARE in error.

Regional Review Center

A peer review organization that reviews medical records for utilization and quality under the TRICARE Regional Review System.

Regional Review System

A part of the Military Health Services System Quality Management Program that does utilization review and quality assurance for medical and surgical services provided to beneficiaries by civilian providers.

Retiree

A former member of the uniformed services who is entitled to retired, retainer or equivalent pay based on duty.

Sponsor

The member of the family who is or was in one of the uniformed services. TRICARE uses the Social Security Number or authorization number of the sponsor or the veteran to identify claims.

TRICARE Extra

This preferred provider option is available in TRICARE areas for TRICARE Standard beneficiaries. Contracted network providers agree to accept a reduced fee for providing services, saving the patient higher cost-shares.

TRICARE Management Activity (formerly OCHAMPUS)

The agency that administers the TRICARE program.

TRICARE Prime

TRICARE's health maintenance organization option. Beneficiaries must enroll for 12 months and pay enrollment fees. All care is coordinated by Primary Care Managers. Provider networks are established by the contractor.

TRICARE Standard

The TRICARE option that allows beneficiaries to choose their providers, both professional and institutional. Beneficiaries must share the cost of care and pay deductibles for outpatient care.

Uniformed Services Hospitals

Includes all military hospitals and designated uniformed services treatment facilities, some of which are former Public Health Service hospitals.

Unproven Devices, Medical Treatment and Procedures

Those devices, treatments or procedures whose safety and efficacy has not been established. Services and supplies considered to be unproven are excluded from TRICARE coverage.

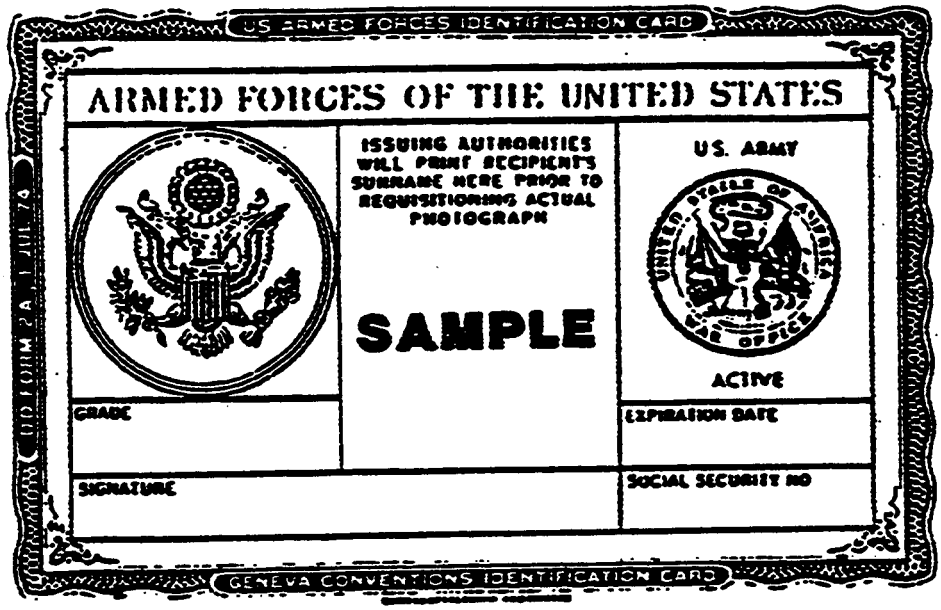
Well-Baby Care

Preventive and routine care to assess the general health of children up to the sixth birthday (includes immunizations).

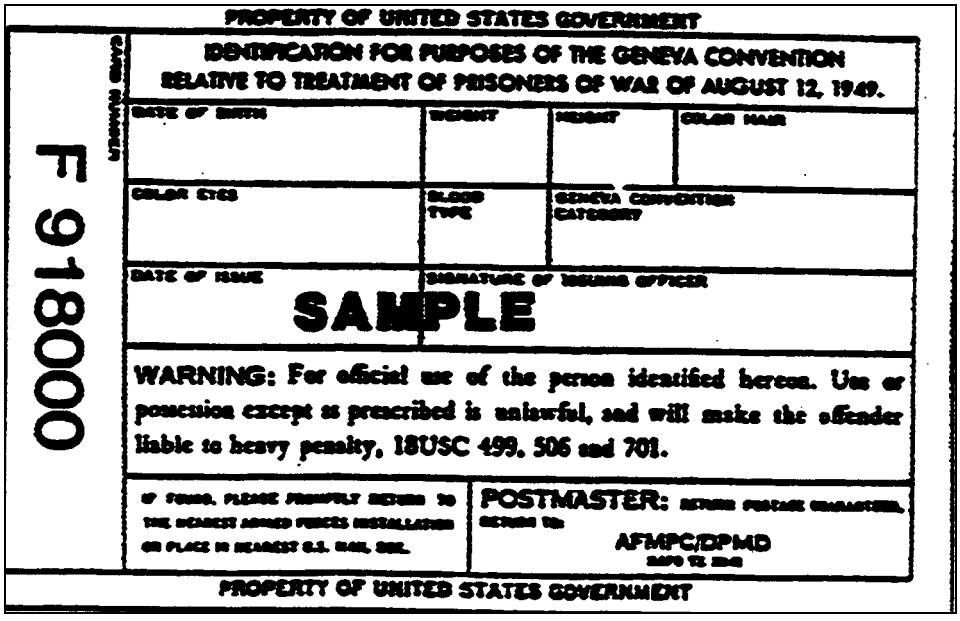
Appendix B

Identification Card Examples

Active Duty
(Green)



DD FORM 2A ARMY, 2AF AIR FORCE, 2CG COAST GUARD, 2MC MARINES, 2N NAVY



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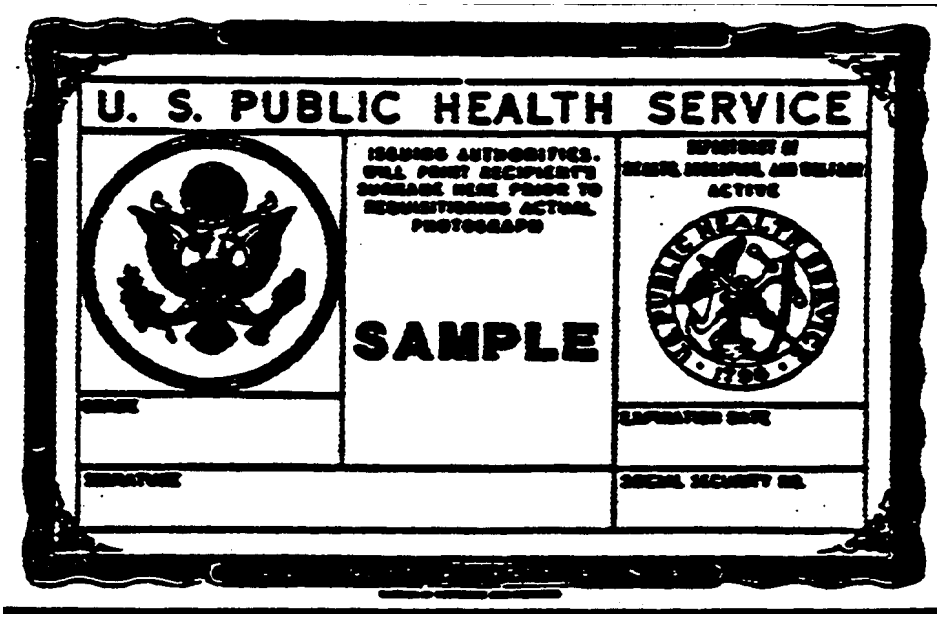
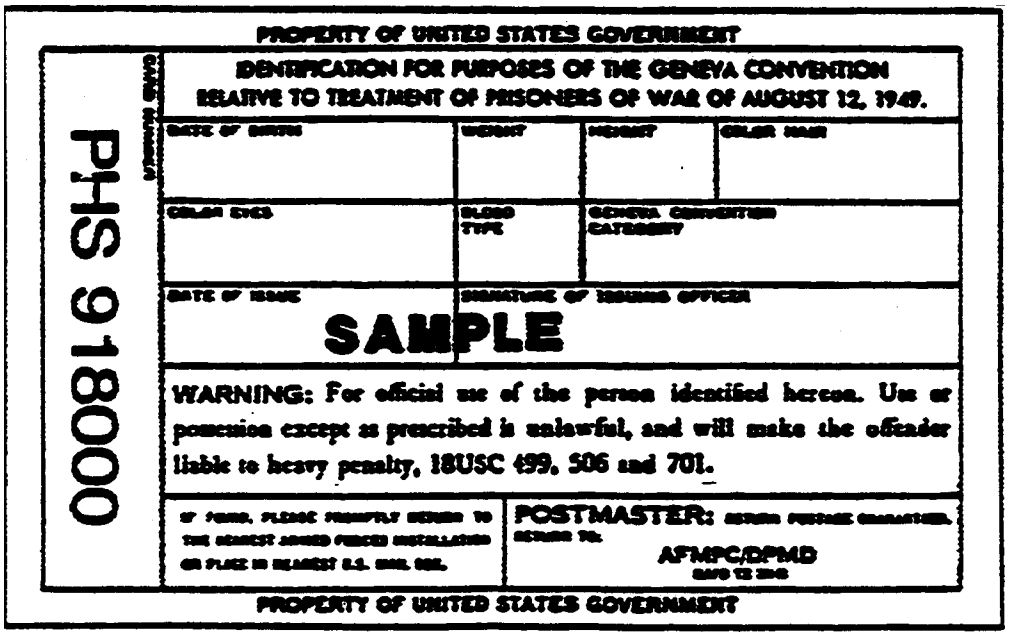
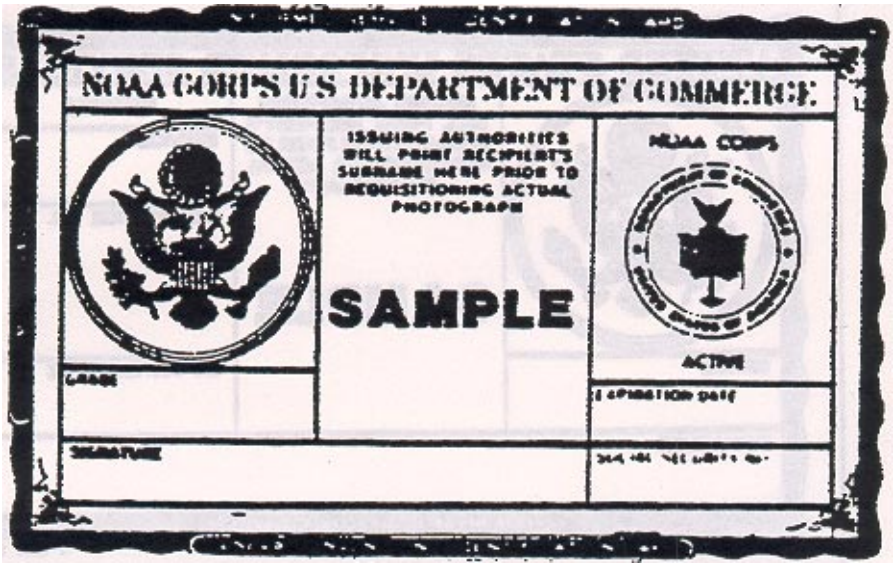
(Green)



PHS 1866-1 (COMMISSIONED CORPS ONLY)



Active Duty
(Green)



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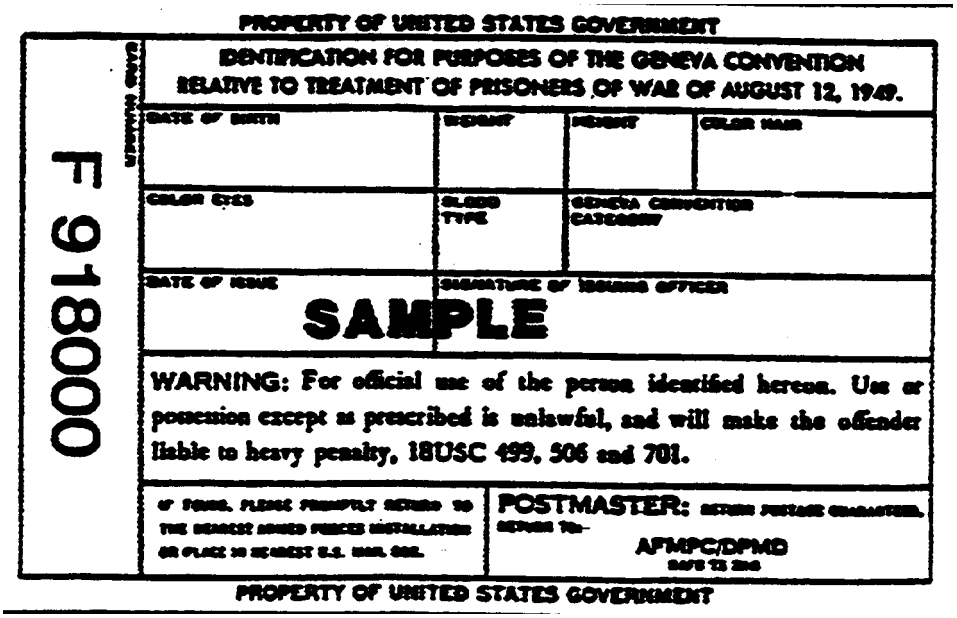
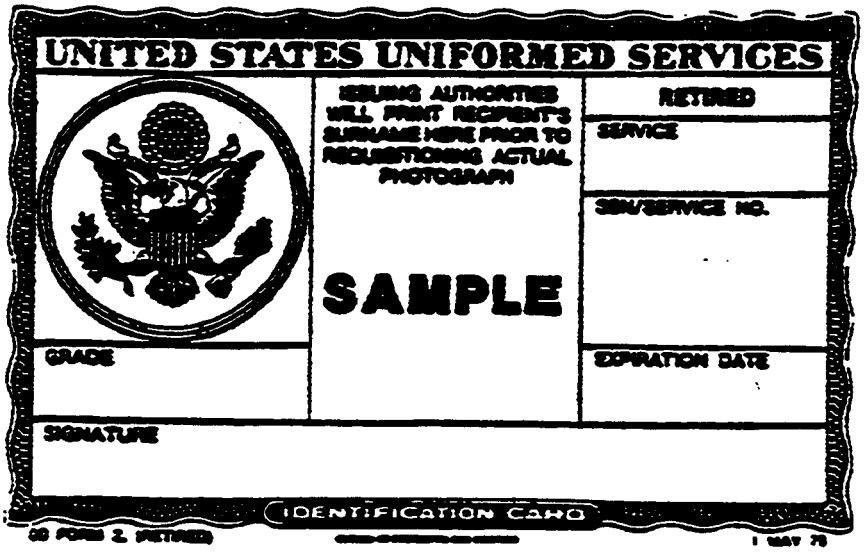
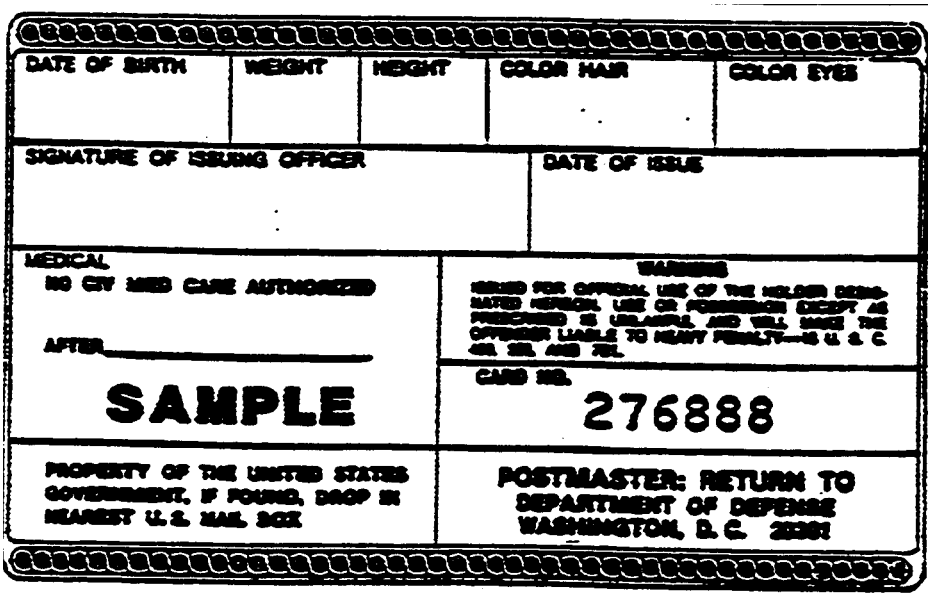


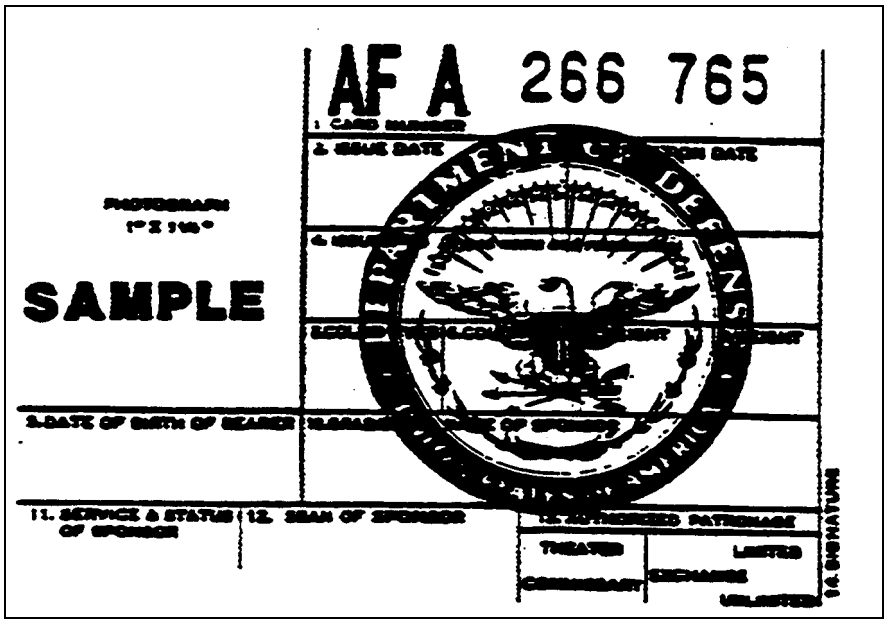
Retired
(Blue or Gray)



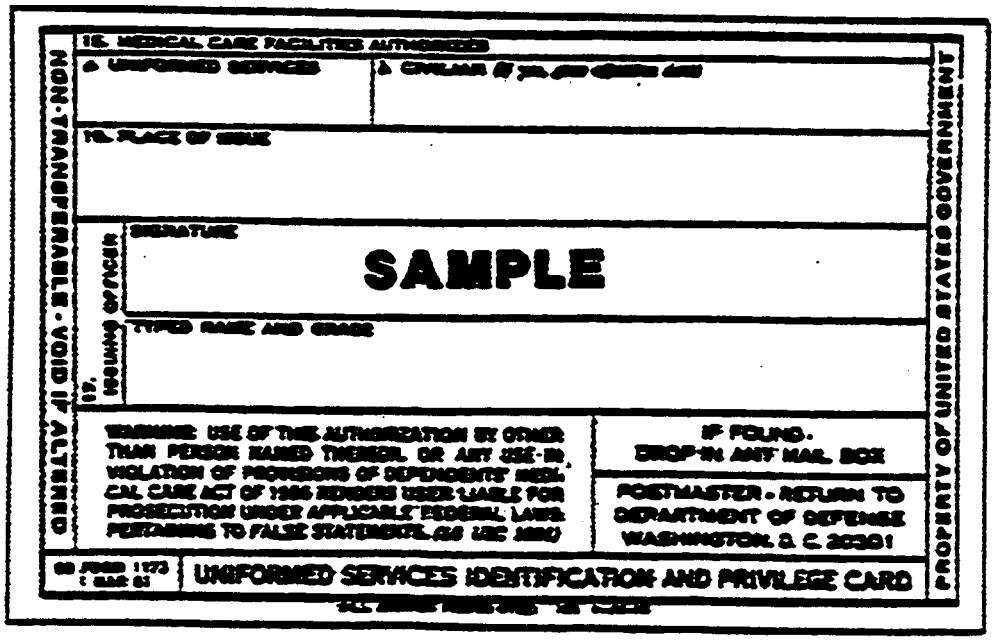
DD FORM 2 (BLUE OR GRAY)
(INCLUDES NOAA AND PHS)



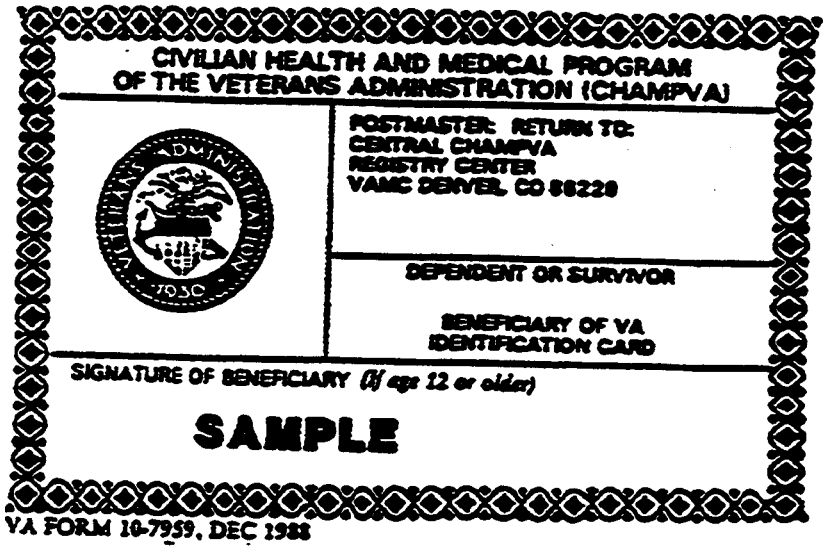
Family Member
(Orange)

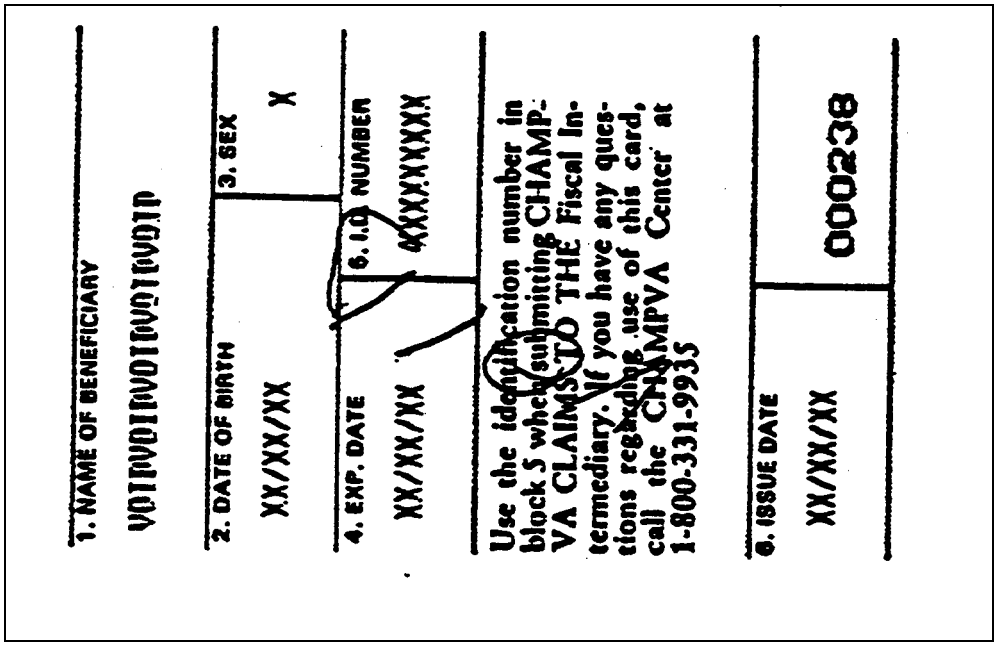


DD FORM 1173



Veterans Administration (CHAMPVA)
(White)





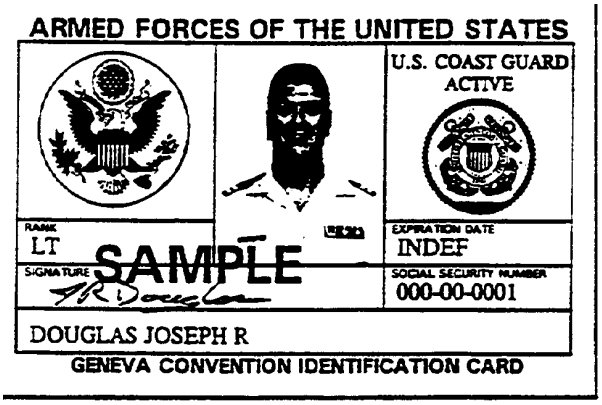
New Identification Card

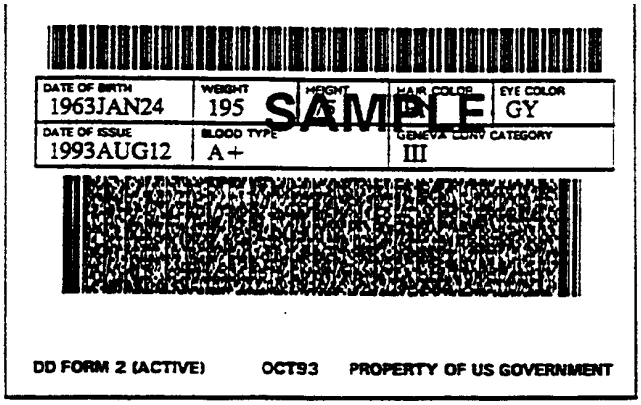
The Department of Defense, in conjunction with the seven Uniformed Services, began issuing a new style of ID card in 1994. The new card is credit-card sized and incorporates a digital photograph image of the bearer, bar codes containing pertinent machine-readable date, and printed identification and entitlement information.

The new cards are being phased in over the next few years. Please honor these cards. They are valid Uniformed Services ID cards.

The color of the cards will remain the same:

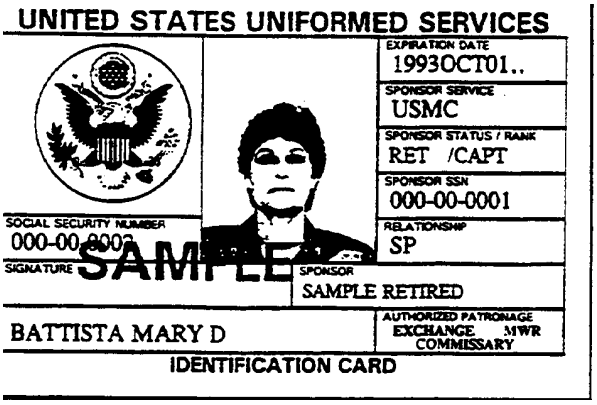
Active duty — green and eligible family members — tan;
Reserve components (guard and reserves) and their eligible family members — red;
Retirees — blue; and their eligible family members — tan.

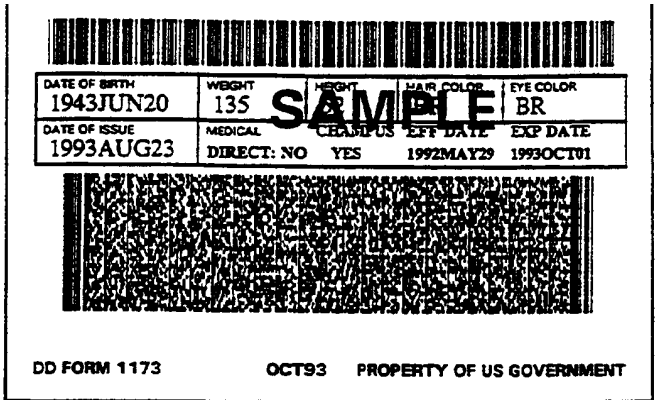




Front **Back**

Sponsor ID Card





Front **Back**

Family Member ID Card

Appendix C — Forms

DD Form 2642

DD Form 2642 is available online, at
http://www.ochampus.mil/ClaimForms/dd2642.pdf

HCFA Form 1500 Instructions

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Department of Defense, Washington Headquarters Services, Directorate for information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302, and to the Office of Management and Budget, Paperwork Reduction Project (0720-0001), Washington, DC 20503.

PROVIDERS AND SUPPLIERS SHOULD USE THESE INSTRUCTIONS FOR COMPLETING THE REVISED HFCA FORM 1500 (DEC 1990) FOR REIMBURSEMENT UNDER TRICARE, FORMERLY THE CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS). THE HCFA FORM 1500 SHOULD BE USED BY ALL INDIVIDUAL HEALTH CARE PROFESSIONALS, INSTITUTIONS SUBMITTING CLAIMS FOR PROFESSIONAL SERVICES AND OTHER NONINSTITUTIONAL PROVIDERS AND SUPPLIERS. THIS FORM IS PRESCRIBED BY HCFA FOR THE MEDICARE PROGRAM AND HAS RECEIVED THE APPROVAL OF THE AMERICAN MEDICAL ASSOCIATION (AMA) COUNCIL ON MEDICAL SERVICES. THESE INSTRUCTIONS REPLICATE MEDICARE INSTRUCTIONS WHERE POSSIBLE BUT THERE ARE SIGNIFICANT DIFFERENCES. PLEASE REFER TO THE INFORMATION BELOW AND THE SPECIFIC INSTRUCTIONS FOR EACH BLOCK.

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IT'S IMPORTANT THAT YOU PAY PARTICULAR ATTENTION TO:

NOTE:
- SUBMIT A SEPARATE CLAIM FORM FOR EACH BENEFICIARY/PATIENT, INCLUDING MOTHER AND NEWBORN.
- SUBMIT ONLY ORIGINAL, SIGNED AND DATED TRICARE/CHAMPUS-AUTHORIZED CLAIM FORMS.

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TRICARE/CHAMPUS PARTICIPATING (ACCEPTING ASSIGNMENT UNDER TRICARE/CHAMPUS)

PARTICIPATION MAY BE ON A CASE-BY-CASE BASIS BY CHECKING "YES" IN BLOCK 27 AND SIGNING THE CLAIMS FORM IN BLOCK 31. YOU MAY CONTACT THE NEAREST MILITARY TREATMENT FACILITY (MTF) OR THE TRICARE/CHAMPUS REGIONAL CONTRACTOR FOR INFORMATION CONCERNING FULL-TIME PARTICIPATING PROVIDER PROGRAMS. IF YOU SUBMIT CLAIMS AS A TRICARE NETWORK PROVIDER, YOU MUST ACCEPT ASSIGNMENT ON EVERY CLAIM. WHEN YOU PARTICIPATE, PAYMENT WILL GO DIRECTLY TO YOU. YOUR PAYMENT WILL BE BASED ON THE TRICARE/CHAMPUS ALLOWABLE CHARGE; THE BENEFICIARY WILL BE RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COST-SHARE AMOUNTS AND ANY NONCOVERED SERVICES. IF YOU DO NOT ACCEPT ASSIGNMENT, THE TRICARE/CHAMPUS CLAIMS PROCESSOR CANNOT RELEASE PAYMENT DATA OR INFORMATION ABOUT A CLAIM TO YOU. SEE "GOVERNMENT PROGRAMS ONLY" ON PAGE 7 FOR ADDITIONAL INFORMATION CONCERNING TRICARE/CHAMPUS PARTICIPATION.

NOTE: "ASSIGNED" SUPERBILLS ARE NOT ACCEPTABLE; YOU MUST FILE YOUR CLAIM ON AN AUTHORIZED TRICARE/CHAMPUS CLAIM FORM.

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IF YOU DO NOT ACCEPT ASSIGNMENT UNDER TRICARE/CHAMPUS

IF YOU DO NOT ACCEPT ASSIGNMENT UNDER TRICARE/CHAMPUS, WE REQUEST THAT YOU COMPLETE THE HCFA FORM 1500 FOR THE BENEFICIARY. PLEASE SIGN AND DATE THE FORM IN BLOCK 31 AND INDICATE IN BLOCK 27 THAT YOU DO NOT ACCEPT ASSIGNMENT. IF YOU DO NOT SIGN/DATE THE CLAIM, IT CANNOT BE ACCEPTED BY THE CLAIMS PROCESSOR.

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NOTICE TO ALL PROVIDERS WHO DO NOT ACCEPT ASSIGNMENT

IN ACCORDANCE WITH THE TRICARE/CHAMPUS REGULATION, A BALANCE BILLING LIMITATION FOR SERVICES PROVIDED BY NONPARTICIPATION PROVIDERS BECAME EFFECTIVE ON NOVEMBER 1, 1993. THIS PROVISION LIMITS NONPARTICIPATING PROVIDERS FROM BILLING TRICARE/CHAMPUS BENEFICIARIES MORE THAN 115 PERCENT OF THE TRICARE/CHAMPUS ALLOWABLE CHARGE. NONPARTICIPATING PROVIDERS WHO DO NOT COMPLY WITH THE LIMITATION SHALL BE SUBJECT TO EXCLUSION FROM THE TRICARE/CHAMPUS PROGRAM AS AUTHORIZED PROVIDERS.

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TRICARE/CHAMPUS ELIGIBILITY

ELIGIBILITY IS BASED ON THE SPONSOR WHO IS THE ACTIVE DUTY, RETIRED OR DECEASED MILITARY SERVICE MEMBER. WHILE THE RETIRED SERVICE MEMBER *IS ELIGIBLE* FOR TRICARE/CHAMPUS, THE *ACTIVE DUTY* SERVICE MEMBER *IS NOT ELIGIBLE*. HOWEVER, YOU MAY FILE CLAIMS USING THE HCFA 1500 FOR ANY SERVICES PROVIDED TO AN ACTIVE DUTY MEMBER. MEDICARE ELIGIBLES ARE NOT TRICARE/CHAMPUS ELIGIBLE UNLESS THEY ARE DEPENDENTS OF ACTIVE DUTY MILITARY PERSONNEL, OR IN CERTAIN CIRCUMSTANCES, WHEN THEY ARE ELIGIBLE BECAUSE OF DISABILITY OR END-STAGE RENAL DISEASE. THE DEFENSE ENROLLMENT ELIGIBILITY AND REPORTING SYSTEM (DEERS) IS USED BY THE CLAMS PROCESSORS TO DETERMINE TRICARE/CHAMPUS ELIGIBILITY. ASK THE PATIENT OR SPONSOR IF THEY ARE ENROLLED ON DEERS SINCE CLAIMS WILL BE DENIED IF THE PATIENT/SPONSOR ELIGIBILITY INFORMATION IS NOT ON DEERS.

YOU SHOULD REQUEST A MILITARY-ISSUED OR VETERANS ADMINISTRATION-ISSUED IDENTIFICATION (I.D.) CARD AS YOUR BASIS FOR DETERMINING TRICARE/CHAMPUS ELIGIBILITY. CHILDREN UNDER 10 MAY NOT HAVE AN I.D. CARD; IF NOT, THE PARENT'S I.D. CARD SHOULD BE USED. IF BOTH PARENTS ARE ACTIVE DUTY SERVICE MEMBERS, ONLY ONE I.D. CARD SHOULD BE USED FOR REPORTING THE SOCIAL SECURITY NUMBER. YOU SHOULD CHECK THE EFFECTIVE AND EXPIRATION DATES ON THE I.D. CARD AND ENSURE THAT THE CARD AUTHORIZES *CIVILIAN* MEDICAL CARE (SEE THE REVERSE SIDE OF THE DEPENDENTS I.D. CARD (DD FORM 1173) BLOCK 15b AND THE REVERSE SIDE OF THE RETIREE'S MILITARY I.D. CARD (DD FORM 2, RETIRED) WHICH PROVIDES A DATE WHEN THE TRICARE/CHAMPUS BENEFICIARY BECOMES ELIGIBLE FOR MEDICARE). WE RECOMMEND THAT A COPY OF BOTH SIDES OF CARD BE RETAINED IN YOUR FILES. THE INSTRUCTIONS FOR BLOCK 6 AND THE TRICARE STANDARD PROVIDER HANDBOOK HAVE ADDITIONAL INFORMATION CONCERNING ELIGIBILITY.

OTHER HEALTH INSURANCE

TRICARE/CHAMPUS IS SECONDARY TO ALL OTHER HEALTH INSURANCES EXCEPT MEDICAID. YOU MUST FIRST SUBMIT THE CLAIM TO THE OTHER HEALTH INSURER (EXCEPT SUPPLEMENTAL PLANS) AND AFTER THAT INSURANCE HAS DETERMINED THEIR LIABILITY, ATTACH THE EXPLANATION OF BENEFITS (EOB) OR WORKSHEET TO THE TRICARE/CHAMPUS CLAIM.

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NONAVAILABILITY STATEMENT REQUIREMENTS

IF YOUR TRICARE/CHAMPUS PATIENT LIVES NEAR A MILITARY TREATMENT FACILITY (GENERALLY, WITHIN A 40-MILE RADIUS OF THE MTF), HE/SHE IS

REQUIRED TO USE THE MTF FOR ALL NONEMERGENCY *INPATIENT* CARE. NAS REQUIREMENTS ALSO APPLY TO UNIFORMED SERVICES TREATMENT FACILITIES. IF CARE IS NOT AVAILABLE IN THE MTF, THE MTF WILL ISSUE THE BENEFICIARY A NONAVAILABILITY STATEMENT (NAS). IF THE BENEFICIARY DOES NOT GET AN NAS BEFORE RECEIVING INPATIENT CARE, TRICARE/CHAMPUS WILL DENY THE CLAIM(S). AN NAS ISSUED OUTSIDE THE UNITED STATES IS NOT VALID FOR CARE IN FACILITIES WHICH ARE LOCATED WITHIN THE UNITED STATES OR PUERTO RICO. CONVERSELY, AN NAS ISSUED WITHIN THE UNITED STATES AND PUERTO RICO IS NOT VALID OUTSIDE THE UNITED STATES AND PUERTO RICO. [NOTE: IF YOU ARE A TRICARE NETWORK PROVIDER AND ARE REFERRING A TRICARE PRIME BENEFICIARY FOR INPATIENT CARE, YOU MUST OBTAIN AN AUTHORIZATION FROM THE TRICARE CONTRACTOR IN LIEU OF AN NAS.]

THE NAS AUTHORIZATION WILL BE ENTERED ON DEERS. (SEE "TRICARE/CHAMPUS ELIGIBILITY" ABOVE FOR INFORMATION ON "DEERS.") IF THE AUTHORIZATION IS NOT ON DEERS THE CLAIMS PROCESSOR WILL DENY THE CLAIM.

NOTE: TRICARE/CHAMPUS WILL NOT PAY FOR CARE JUST BECAUSE A MILITARY TREATMENT FACILITY ISSUED AN NAS. THE CARE IS SUBJECT TO BENEFITS AND SERVICES AUTHORIZED BY LAW AND THE CARE MUST BE PROVIDED BY AN AUTHORIZED TRICARE/CHAMPUS PROVIDER.

NAS EXCEPTIONS: A NONAVAILABILITY STATEMENT IS NOT REQUIRED FOR A BONA FIDE MEDICAL EMERGENCY, FOR BENEFICIARIES WITH PRIMARY HEALTH INSURANCE COVERAGE, FOR CARE UNDER THE PROGRAM FOR PERSONS WITH DISABILITIES, FOR ADMISSIONS TO APPROVED SKILLED NURSING FACILITIES, RESIDENTIAL PSYCHIATRIC TREATMENT CENTERS FOR CHILDREN AND ADOLESCENTS, SPECIALIZED TREATMENT FACILITIES, CHRISTIAN SCIENCE SANATORIA, OR FOR CARE IN A SCHOOL INFIRMARY.

MENTAL HEALTH CLAIMS

ALL *INPATIENT* MENTAL HEALTH CARE REQUIRES PREAUTHORIZATION.

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BILLINGS FOR MORE THAN ONE PROVIDER ON A SINGLE CLAIM

WHEN BILLING FOR MORE THAN ONE PROVIDER ON A SINGLE CLAIM, YOU MUST INCLUDE EACH PROVIDER'S NAME AND SPECIALTY IN BLOCK 24 NEXT TO THE SERVICE PROVIDED. BLOCKS 24H THROUGH 24K SHOULD BE USED FOR THIS PURPOSE FOR MENTAL HEALTH CLAIMS. THE PROVIDER'S PROFESSIONAL DESIGNATION MUST BE PROVIDED; i.e., MSW. THIS ALSO APPLIES TO SERVICES BY PHYSICIANS' ASSISTANTS OR ANY RENDERING PROVIDER OTHER THAN AN INDIVIDUAL PROVIDER SHOWN IN BLOCK 33.

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PHYSICAL LOCATION ADDRESS

IT'S IMPORTANT THAT YOU PROVIDE THE ADDRESS WHERE YOUR OFFICE IS LOCATED IN BLOCK 33. EVEN THOUGH BLOCK 33 SPECIFIES THE BILLING ADDRESS, TRICARE/CHAMPUS MUST HAVE YOUR OFFICE LOCATION ADDRESS WHERE THE SERVICE WAS PROVIDED. RADIOLOGISTS, PATHOLOGISTS AND ANESTHESIOLOGISTS MAY USE THEIR BILLING ADDRESS IF THEY HAVE NO PHYSICAL ADDRESS.

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TIMELY FILING REQUIREMENTS

ALL CLAIMS MUST BE FILED NO LATER THAN ONE YEAR AFTER THE SERVICES ARE PROVIDED; OR FOR INPATIENT CARE, ONE YEAR FROM THE DATE OF DISCHARGE. CONTACT A TRICARE/CHAMPUS HEALTH BENEFITS ADVISOR OR TRICARE MANAGEMENT ACTIVITY-AURORA IF YOU NEED THE NAME AND ADDRESS OF YOUR CLAIMS PROCESSOR. IF A CLAIM IS RETURNED FOR ADDITIONAL INFORMATION, IT MUST BE RESUBMITTED BY THE FILING DEADLINE, OR WITHIN 90 DAYS OF THE NOTICE — WHICHEVER DATE IS LATER.

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WHERE TO FILE A CLAIM

SINCE TRICARE MANAGEMENT ACTIVITY-AURORA IS CONDUCTING VARIOUS DEMONSTRATIONS AND ALTERNATIVE HEALTH CARE PROGRAMS THAT MAY NOT FALL WITHIN THE REGIONAL TRICARE/CHAMPUS CONTRACTOR'S JURISDICTION, YOU SHOULD CONTACT THE REGIONAL TRICARE/CHAMPUS CONTRACTOR, THE HEALTH BENEFITS ADVISOR AT THE NEAREST MILITARY TREATMENT FACILITY OR TRICARE MANAGEMENT ACTIVITY-AURORA IF YOU ARE NOT SURE WHERE TO FILE THE CLAIM.

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ELECTRONIC SUBMISSIONS, AND PIN-FED OR LASER-PRINTED HCFA FORM 1500

IF YOU ELECTRONICALLY SUBMIT OR USE LASER-PRINTED OR PIN-FED VERSIONS OF THE HCFA FORM 1500, CONTACT YOUR TRICARE CONTRACTOR FOR REQUIREMENTS AND FOR INFORMATION CONCERNING COMPLIANCE WITH CERTIFICATIONS AND ACKNOWLEDGMENTS ON THE REVERSE SIDE OF THE FORM.

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THE FOLLOWING ARE PROVIDER AND PATIENT CERTIFICATIONS AND ACKNOWLEDGMENTS WHICH APPEAR ON THE REVERSE SIDE OF THE REVISED HCFA FORM 1500.

GOVERNMENT PROGRAMS ONLY

A PATIENT'S SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF INFORMATION NECESSARY TO PROCESS THE CLAIM AND CERTIFIES THAT THE INFORMATION PROVIDED IN BLOCKS *1 THROUGH 12* IS TRUE, ACCURATE AND COMPLETE. IF ITEM 9 IS COMPLETED, THE PATIENT'S SIGNATURE AUTHORIZES RELEASE OF THE INFORMATION TO THE HEALTH PLAN OR AGENCY SHOWN. IN MEDICARE ASSIGNED OR TRICARE/CHAMPUS PARTICIPATION CASES, THE PHYSICIAN AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER OR TRICARE/CHAMPUS CONTRACTOR AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE AND NONCOVERED SERVICES. COINSURANCE AND THE DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER OR TRICARE/CHAMPUS CONTRACTOR IF THIS IS LESS THAN THE CHARGE SUBMITTED. TRICARE/CHAMPUS IS NOT A HEALTH INSURANCE PROGRAM AND RENDERS PAYMENT FOR HEALTH BENEFITS PROVIDED THROUGH MEMBERSHIP AND AFFILIATION WITH THE UNIFORMED SERVICES.

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SIGNATURE OF PHYSICIAN OR SUPPLIER

I CERTIFY THAT THE SERVICES SHOWN ON THIS FORM WERE MEDICALLY INDICATED AND NECESSARY FOR THE HEALTH OF THE PATIENT AND WERE PERSONALLY RENDERED BY ME OR WERE RENDERED INCIDENT TO MY PROFESSIONAL SERVICE BY MY EMPLOYEE UNDER IMMEDIATE PERSONAL SUPERVISION, EXCEPT AS OTHERWISE EXPRESSLY PERMITTED BY TRICARE/CHAMPUS REGULATIONS.

FOR SERVICES TO BE CONSIDERED AS "INCIDENT" TO A PHYSICIAN'S PROFESSIONAL SERVICE: 1) THEY MUST BE RENDERED UNDER THE PHYSICIAN'S IMMEDIATE PERSONAL SUPERVISION BY HIS/HER EMPLOYEE; 2) THEY MUST BE AN

INTEGRAL, ALTHOUGH INCIDENTAL PART OF A COVERED PHYSICIAN'S SERVICE; 3) THEY MUST BE OF KINDS COMMONLY FURNISHED IN PHYSICIAN'S OFFICES; AND 4) THE SERVICES OF NONPHYSICIANS MUST BE INCLUDED ON THE PHYSICIAN'S BILL.

FOR TRICARE/CHAMPUS CLAIMS, I FURTHER CERTIFY THAT I (OR AN EMPLOYEE WHO RENDERED SERVICES) AM NOT AN ACTIVE DUTY MEMBER OF THE UNIFORMED SERVICES OR A CIVILIAN EMPLOYEE OF THE UNITED STATES GOVERNMENT OR A CONTRACT EMPLOYEE OF THE UNITED STATES GOVERNMENT, EITHER CIVILIAN OR MILITARY (REFER TO 5 USC 5536).

NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION ON THE CLAIM FORM TO RECEIVE PAYMENT FROM FEDERAL FUNDS, MAY, UPON CONVICTION, BE SUBJECT TO FINE AND IMPRISONMENT UNDER APPLICABLE FEDERAL LAWS.

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PROVIDERS SHOULD INFORM BENEFICIARIES OF THE FOLLOWING:

WE ARE AUTHORIZED BY HCFA, TRICARE/CHAMPUS AND OWCP TO ASK YOU FOR INFORMATION NEEDED IN THE ADMINISTRATION OF THE MEDICARE, TRICARE/CHAMPUS, FECA AND BLACK LUNG PROGRAMS. AUTHORITY TO COLLECT INFORMATION IS IN SECTION 205(a), 1872 AND 1875 OF THE SOCIAL SECURITY ACT AS AMENDED AND 44 USC 3101; 41 CFR 101 ET SEQ AND 10 USC 1079 AND 1086; 5 USC 8101 ET SEQ; AND 30 USC 10 ET SEQ; 38 USC 613; E.O. 9397.

THE INFORMATION WE OBTAIN TO COMPLETE CLAIMS UNDER THESE PROGRAMS IS USED TO IDENTIFY YOU AND TO DETERMINE YOUR ELIGIBILITY. IT IS ALSO USED TO DECIDE IF THE SERVICES AND SUPPLIES YOU RECEIVED ARE COVERED BY THESE PROGRAMS AND TO ENSURE THAT PROPER PAYMENT IS MADE. THE INFORMATION MAY ALSO BE GIVEN TO OTHER PROVIDERS OF SERVICES, CARRIERS, INTERMEDIARIES, MEDICAL REVIEW BOARDS, HEALTH PLANS AND OTHER ORGANIZATIONS OR FEDERAL AGENCIES, FOR THE EFFECTIVE ADMINISTRATION OF FEDERAL PROVISIONS THAT REQUIRE OTHER THIRD PARTY PAYERS TO PAY PRIMARY TO FEDERAL PROGRAMS, AND AS OTHERWISE NECESSARY TO ADMINISTER THESE PROGRAMS. FOR EXAMPLE, IT MAY BE NECESSARY TO DISCLOSE INFORMATION ABOUT THE BENEFITS YOU HAVE USED TO A HOSPITAL OR DOCTOR.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE/CHAMPUS, FECA AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT).

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TRICARE/CHAMPUS PRIVACY ACT STATEMENT

AUTHORITY:	44 U.S.C. 3101; 10 U.S.C. 1079 AND 1086; 38 U.S.C. 613; E.O. 9397.
PRINCIPAL PURPOSE(S):	TO EVALUATE ELIGIBILITY FOR MEDICAL CARE PROVIDED BY CIVILIAN SOURCES AND TO ISSUE PAYMENT UPON ESTABLISHMENT OF ELIGIBILITY AND DETERMINATION THAT THE SERVICES/SUPPLIES RECEIVED ARE AUTHORIZED BY LAW.
ROUTINE USE(S):	INFORMATION FROM CLAIMS AND RELATED DOCUMENTS MAY BE GIVEN TO THE DEPARTMENT OF VETERANS AFFAIRS, THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND/OR THE DEPARTMENT OF TRANSPORTATION CONSISTENT WITH THEIR STATUTORY ADMINISTRATIVE RESPONSIBILITIES UNDER TRICARE/CHAMPUS; TO THE DEPARTMENT OF JUSTICE FOR REPRESENTATION OF THE SECRETARY OF DEFENSE IN CIVIL ACTIONS; TO THE INTERNAL REVENUE SERVICE AND PRIVATE COLLECTION AGENCIES AND CONSUMER REPORTING AGENCIES IN CONNECTION WITH RECOUPMENT CLAIMS; AND TO CONGRESSIONAL OFFICES IN RESPONSE TO INQUIRIES MADE AT THE REQUEST OF THE PERSON TO WHOM A RECORD PERTAINS. APPROPRIATE DISCLOSURES MAY BE MADE TO OTHER FEDERAL, STATE, LOCAL, FOREIGN GOVERNMENT AGENCIES, PRIVATE BUSINESS ENTITIES, AND INDIVIDUAL PROVIDERS OF CARE, ON MATTERS RELATING TO ENTITLEMENT, CLAIMS ADJUDICATION, FRAUD, PROGRAM ABUSE, UTILIZATION REVIEW, QUALITY ASSURANCE, PEER REVIEW, PROGRAM INTEGRITY, THIRD-PARTY LIABILITY, COORDINATION OF BENEFITS, AND CIVIL AND CRIMINAL LITIGATION RELATED TO THE OPERATION OF TRICARE/CHAMPUS.
DISCLOSURE AND EFFECTS ON INDIVIDUALS NOT PROVIDING REQUESTED INFORMATION:	VOLUNTARY, HOWEVER, FAILURE TO PROVIDE INFORMATION WILL RESULT IN DELAY IN PAYMENT OR DENIAL OF CLAIM.

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REVISED FORM HCFA 1500 INSTRUCTIONS FOR PROVIDERS/SUPPLIERS COMPLETING FORMS FOR TRICARE/CHAMPUS BENEFICIARIES

WHEN THE INSTRUCTIONS REFER TO THE "INSURED," THE INSURED MEANS THE MILITARY "SPONSOR." THE SPONSOR IS THE ACTIVE DUTY, RETIRED, OR DECEASED SERVICE MEMBER.

NOT ALL BLOCKS ON THE FORM HCFA 1500 MUST BE COMPLETED FOR TRICARE/CHAMPUS – SEE THE INDIVIDUAL BLOCK INSTRUCTIONS FOR THE TRICARE/CHAMPUS REQUIREMENTS.

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PATIENT AND SPONSOR INFORMATION (BLOCKS 1 – 12)

BLOCK 1: **CHECK APPLICABLE PROGRAM.** Check the appropriate box for

REQUIRED. TRICARE/CHAMPUS.

BLOCK 1a: REQUIRED. **SPONSOR'S I.D. NUMBER (FOR THE PROGRAM IN BLOCK 1).**

CHAMPUS: Enter the sponsor's Social Security Number (SSN). Do not provide the patient's SSN unless the patient and sponsor are the same. If a sponsor is an active duty security agent, enter "SECURITY." (See the definition for sponsor in the "TRICARE/CHAMPUS Eligibility Section" on page 2.

NATO: If a NATO beneficiary, enter "NATO."

BLOCK 2: REQUIRED. **PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL).** Enter the last name, first name and middle initial of the individual receiving care or services. Do not use nicknames or abbreviations.

BLOCK 3: REQUIRED. **PATIENT'S BIRTH DATE (MM/DD/YY) AND SEX (CHECK THE BOX).** Enter the date of birth of the patient (MM/DD/YY) as shown on the I.D. Card and check the appropriate box for the patient's sex.

BLOCK 4: REQUIRED. **SPONSOR'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL).** Enter the sponsor's last name, first name and middle initial. Do not use nicknames or abbreviations. Enter "same" if the sponsor and patient are the same.

BLOCK 5: REQUIRED. **PATIENT'S ADDRESS (NUMBER, STREET, CITY, STATE, ZIP CODE, TELEPHONE NUMBER WITH AREA CODE).** Enter the complete address of the patient's place of residence at the time of service (street number, street name, apartment number, city, state, zip code) and the home telephone number to include the area code. *Do not provide a Post Office Box Number; provide the actual place of residence.* If a rural address, the address must contain the route and box number. An APO/FPO address should not be used for a patient's mailing address unless that person is actually residing overseas. Be sure to include both daytime and evening telephone numbers so the claims processor can contact the patient if necessary.

BLOCK 6: REQUIRED. **PATIENT'S RELATIONSHIP TO SPONSOR (CHECK BOX FOR SELF, SPOUSE, CHILD, OTHER).** If the patient is the sponsor check the "SELF" block or provide the relationship of the patient to the sponsor. If "OTHER" is checked, indicate how the patient is related to the sponsor: i.e., former spouse, parent (PARENTS, PARENTS-IN-LAW, STEPPARENTS, PARENTS BY ADOPTION ARE *NOT* TRICARE/CHAMPUS ELIGIBLE; THESE CATEGORIES OF DEPENDENTS MAY HAVE I.D. CARDS WITH PRIVILEGES FOR THE MILITARY TREATMENT FACILITY, BUT NOT FOR TRICARE/CHAMPUS BENEFITS. GRANDCHILDREN ARE NOT ELIGIBLE UNLESS THEY ARE LEGALLY ADOPTED). ENSURE THAT AN I.D. CARD AUTHORIZES *CIVILIAN* MEDICAL BENEFITS. See the reverse side of the dependent's I.D. card (DD Form 1173), Block 15.b, or the reverse side of the retiree's I.D. card (DD Form 2, Retired). An unnumbered block provides a date when civilian medical care is no longer authorized; i.e., when the TRICARE/CHAMPUS beneficiary becomes eligible for Medicare. If the child is a stepchild, check the box for child.

BLOCK 7: REQUIRED. **SPONSOR'S ADDRESS (NUMBER, APARTMENT NUMBER, STREET, CITY, STATE, ZIP CODE, TELEPHONE NUMBER WITH AREA CODE).** Enter the address for the active duty sponsor's duty station or the retiree's mailing address. If the address is the same as the patient's, enter "same." If the sponsor resides overseas, enter the APO/FPO address.

BLOCK 8: REQUIRED. **PATIENT STATUS (CHECK BOXES FOR SINGLE, MARRIED, OTHER, EMPLOYED, FULL-TIME STUDENT, PART-TIME STUDENT).** Check the appropriate box for the patient's marital status and whether employed or a student.

BLOCK 9: **OTHER INSURED'S NAME (LAST NAME, FIRST NAME AND MIDDLE INITIAL).** Enter the name of the insured if different from that shown in Block 2 (patient). For

REQUIRED. example, the patient may be covered under insurance held by a spouse, parent or other person. (Blocks 11a – d should be used to report other health insurance held by the patient).

NOTE: BLOCK 11d SHOULD BE COMPLETED PRIOR TO DETERMINING THE NEED FOR COMPLETING BLOCKS 9a THROUGH 9d. IF BLOCK 11d IS CHECKED "YES," BLOCKS 9a THROUGH 9d MUST BE COMPLETED PRIOR TO THE CLAIMS PROCESSOR ADJUDICATING THE CLAIM.

BLOCK 9a: REQUIRED. **OTHER INSURED'S POLICY OR GROUP NUMBER.** Provide the policy number or the group number of the other insured's policy.

BLOCK 9b DESIRABLE: **OTHER INSURED'S DATE OF BIRTH (MM/DD/YY) AND SEX.** Enter the other insured's date of birth and check the appropriate box for sex.

BLOCK 9c: REQUIRED. **EMPLOYER'S NAME OR SCHOOL NAME.** Enter the name of the employer or the name of the school.

BLOCK 9d: REQUIRED. **INSURANCE PLAN NAME OR PROGRAM NAME.** Enter the name of the insurance plan or the program name where the individual has other health insurance coverage. On an attached sheet, provide a complete mailing address for all other insurance information and enter the word "attachment" in Block 10d. If the patient is covered by insurance that is supplemental to TRICARE/CHAMPUS, see Block 11c for instructions. If your patient is covered by a Health Maintenance Organization (HMO), attach a copy of the brochure showing that the service is not covered by the HMO.

BLOCK 10a-c: REQUIRED. **PATIENT'S CONDITION RELATED TO EMPLOYMENT (CURRENT OR PREVIOUS), AUTO ACCIDENT (PLACE, STATE), OTHER ACCIDENT (CHECK THE BOXES).** Check "Yes" or "No" to indicate whether employment, auto liability or other accident involvement applies to one or more of the services described in Block 24. Provide information concerning potential third party liability. ***If this case resulted from an automobile accident, indicate the state where the accident occurred.*** The contractor will contact the patient for potential third party liability information. When a third party is involved, the beneficiary is required to complete DD Form 2527,

"Statement of Personal Injury – Possible Third Party Liability." The form may be obtained from the contractor.

BLOCK 10d: REQUIRED. Use this block to indicate that there is an other health insurance attachment.

BLOCK 11: REQUIRED. **INSURED'S POLICY, GROUP OR FECA NUMBER.** If the patient has other insurance enter the policy or group number. Indicate if the patient is covered by Medicare. (Blocks 9a –d should be used to report another primary insurance or other health insurance held by *family members* that includes coverage of the patient).

BLOCK 11a: REQUIRED. **INSURED'S DATE OF BIRTH (MM/DD/YY) AND SEX (CHECK BOX).** Enter the date of birth and sex if different from Block 3.

BLOCK 11b: REQUIRED. **EMPLOYER'S NAME OR SCHOOL NAME.** Enter the employer's or school's name if applicable.

BLOCK 11c: REQUIRED. **INSURANCE PLAN NAME OR PROGRAM NAME.** Enter the insurance plan or program name. If your patient is covered by a Health Maintenance Organization (HMO), attach a copy of the brochure showing that the service is *not* covered by the HMO. If the patient has "supplemental" TRICARE/CHAMPUS coverage, it is not necessary to file with that insurance first unless the insurance can be considered a primary plan. For TRICARE/CHAMPUS purposes, supplemental policies are those that are specifically designed to be supplemental to TRICARE/CHAMPUS health benefits,

e.g., payment of the beneficiary's TRICARE/CHAMPUS cost-share, deductible liability.

NOTE: TRICARE/CHAMPUS is secondary to all other health insurance except Medicaid. You must first submit the claim to the other health insurer (except for supplemental plans) and after that insurance has determined their liability, attach the Explanation of Benefits or work sheet to the TRICARE/CHAMPUS claim.

BLOCK 11d: REQUIRED. **IS THERE ANOTHER HEALTH BENEFIT PLAN?** Check "yes" or "no" to indicate if there is, or is not, another primary health benefit plan. For example, the patient may be covered under insurance held by a spouse or some other person.

BLOCK 12: REQUIRED. **PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE AND DATE (READ BACK OF FORM BEFORE SIGNING). I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.** Unless the signature is on file,***** the beneficiary or other authorized person must sign (as shown on I.D. Card) the claim authorizing the release of medical information necessary to pay the claim. The date of signature must be provided. If the patient is under 18 years old, either parent should sign unless the services are confidential. If the patient is 18 or older, but cannot sign the claim, the person who signs must be either the legal guardian, or in the absence of a legal guardian, a spouse or parent of the patient. The signer should write his/her name in BLOCK 12, and sign the claim. A statement must be attached to the claim giving the signer's full name and address, relationship to the patient and the reason the patient is unable to sign. Also included must be documentation of the signer's appointment as a legal guardian or if a power of attorney has been issued or a statement that a legal guardian has not been appointed if such is the case. There are other signature requirements if the patient is deceased; contact a Health Benefits Advisor or claims processor if you need assistance.

*** NOTE: CONTACT YOUR CLAIMS PROCESSOR OR HEALTH BENEFITS ADVISOR FOR INFORMATION CONCERNING SIGNATURE ON FILE REQUIREMENTS.**

BLOCK 13: NOT REQUIRED. **INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW.**

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PROVIDER OR SUPPLIER INFORMATION (BLOCKS 14-33)

BLOCK 14: DESIRABLE. **DATE OF CURRENT ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP).** Enter the date of current illness, injury or pregnancy.

BLOCK 15: DESIRABLE. **IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY (GIVE FIRST DATE MM/DD/YY).** Provide the first date when the patient had same or similar illness.

BLOCK 16: DESIRABLE. **DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION.** Enter date if patient is unable to work.

BLOCK 17: REQUIRED. **NAME OF REFERRING PHYSICIAN OR OTHER SOURCE.** Provide the name and address of the physician, institutional provider or other source who referred the patient to the provider of the services identified on this claim. This is required for all consultation services. If your patient was referred from a Military Treatment Facility (MTF), enter the name of the MTF and attach the DD Form 2161 or SF 513, "Referral for Civilian Medical Care."

BLOCK 17a: DESIRABLE. **I.D. NUMBER OF REFERRING PHYSICIAN.** Enter the referring physician's federal tax I.D. Number or Social Security Number.

BLOCK 18: REQUIRED. **HOSPITALIZATION DATES RELATED TO CURRENT SERVICES.** Provide the from and to dates (MMDDYY) of a hospitalization relating to the medical/surgical services being billed for on the claim.

BLOCK 19: **RESERVED FOR LOCAL USE.**

BLOCK 20: REQUIRED. **OUTSIDE LAB? (CHECK THE BOX); CHARGES.** Indicate whether the laboratory work was performed outside of the physician's/supplier's office and the total charged by the laboratory for the work being reported on the claim.

BLOCK 21: REQUIRED. **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1 AND 2 TO ITEM 24E BY LINE ITEM).** Enter – by ICD-9-CM code – the diagnosis/condition of the patient. Enter up to four codes in priority order.

BLOCK 22: NOT REQUIRED. **MEDICAID RESUBMISSION**

BLOCK 23: REQUIRED BY SOME PROGRAMS. **PRIOR AUTHORIZATION NUMBER.** Attach a copy of the authorization; i.e., mental health preauthorization, heart-lung transplant authorization.

BLOCK 24: REQUIRED. **BILLING INFORMATION.** Provide, by service, the information required by Blocks 24A through 24G: Date(s) of Service (from and to dates); Place of Service (code); Type of Service (code); Procedures, Services or Supplies (explain unusual circumstances) (CPT-4 codes are required by TRICARE/CHAMPUS); Diagnosis Code (ICD-9-CM codes); Charges; Days or Units.

BLOCK 24a: REQUIRED. **DATE(S) OF SERVICE (FROM AND TO).** Enter the month, day and year for each procedure/service or supply. If "from" and "to" dates are shown here for a series of identical services, enter the number in 24g.

BLOCK 24b: REQUIRED. **PLACE OF SERVICE (CODE).** Enter the appropriate "Place of Service" Code for each service from the attached list.

BLOCK 24c: REQUIRED. **TYPE OF SERVICE (CODE).** Enter the appropriate "Type of Service" Code for each line item. Refer to the attached list.

BLOCK 24d: REQUIRED. **PROCEDURES, SERVICES OR SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES).** Enter the appropriate CPT-4 Code for each service. When Not Otherwise Classified (NOC) codes are submitted; e.g., supplies and injections, provide a narrative of the service.

BLOCK 24e: REQUIRED. **DIAGNOSIS CODE.** Enter the diagnosis reference number (i.e., up to four ICD-9-CM Codes) as shown in Block 21, to relate the date of service and the procedures performed to the appropriate diagnosis. If multiple procedures are performed, enter the diagnosis code reference number for each service.

BLOCK 24f: REQUIRED. **CHARGES.** Enter the charges for each listed service.

BLOCK 24g: REQUIRED. **DAYS OR UNITS.** Provide the days or units for each line item. This block should be used for multiple visits for identical services, number of miles, units of supplies or oxygen volume. If anesthesia, provide the beginning and end-time of administration.

BLOCK 24h: NOT **EPSDT FAMILY PLANNING.**

REQUIRED.

BLOCK 24i: DESIRABLE. **EMG.** Check this block to indicate that the service was provided in a hospital emergency room.

BLOCK 24j: NOT REQUIRED. **COB.**

BLOCK 24k: **RESERVED FOR LOCAL USE.**

NOTE: If billing for more than one provider on the claim, you must include each provider's name and specialty. Blocks 24h through 24k should be used for this purpose. Also use these blocks to report the subidentifier assigned by the claims processor.

BLOCK 25: REQUIRED. **FEDERAL TAX I.D. NUMBER (SSN/EIN).** Enter the physician's or supplier's Federal Tax I.D. (Employer Identification Number). If there is no Federal Tax I.D. Number, enter the Social Security Number.

BLOCK 26: DESIRABLE. **PATIENT'S ACCOUNT NUMBER.** Enter the patient's account number assigned by the provider.

BLOCK 27: REQUIRED. **ACCEPT ASSIGNMENT? (CHECK BOX). SEE THE REVERSE SIDE OF THE FORM FOR GOVERNMENT INFORMATION. DO NOT LEAVE THIS BLOCK BLANK.** Check "Yes" if you accept assignment under TRICARE/CHAMPUS; "No" if you do not. Failure to complete this block results in nonacceptance of assignment. "Accept assignment" means the provider has agreed to be a TRICARE/CHAMPUS participating provider on the claim and will accept the allowable charge determination made by the claims processor as the total amount payable and the patient is responsible only for the deductible, cost-share and noncovered services. When a provider accepts assignment, payment will be made to the provider. If the provider does not accept assignment, payment will be made to the patient/sponsor.

BLOCK 28: REQUIRED. **TOTAL CHARGES**. Enter the total charges for the services being reported on the claim, i.e., total of all charges in Block 28.

BLOCK 29: REQUIRED. **AMOUNT PAID**. Enter the amount received by the provider or supplier from the other health insurance(s). If the amount includes payment by any other health insurances, the other health insurance EOB, work sheet or denial showing the amounts paid must be attached to the TRICARE/CHAMPUS claim. Payment from the beneficiary should not be included.

BLOCK 30: NOT REQUIRED. **BALANCE DUE.** Provide the balance due (Block 29 subtracted from the charges in Block 28).

BLOCK 31: REQUIRED. **SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS. DATE OF SIGNATURE. (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THERE OF.)** You *must* sign and date the claim form whether or not you accept assignment. Block 27 indicates whether you agree to accept assignment. If you indicate NO in that block, payment will go to the beneficiary.

BLOCK 32: REQUIRED. **NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE).** Provide the name and physical location address (street name and number, city, state and zip code) of the hospital, nursing facility, laboratory or any facility other than the patient's home or physician's office. For Partnership Providers, indicate the name of the Military Treatment Facility.

BLOCK 33: **PHYSICIAN'S/SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE**

REQUIRED. **NUMBER.** Enter the name, complete address (including street name and number, city, state, and zip code) and telephone number (including area code) where your office is physically located. Radiologists, pathologists, and anesthesiologists may use their billing address if they have no physical address.

DESIRABLE. **PIN (PROVIDER IDENTIFICATION NUMBER)**. If there is a TRICARE/CHAMPUS provider number assigned by the processor, indicate in this block.

NOT REQUIRED. **GRP (GROUP).**

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PLACE OF SERVICE CODES AND DEFINITIONS (CODES TO BE USED IN BLOCK 24B)

11 OFFICE
Location, other than a hospital, Skilled Nursing Facility, Community Health Center, State or Local Public Health Clinic where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.

12 HOME
Location, other than a hospital or other facility, where the patient receives care in a private residence.

21 INPATIENT HOSPITAL
A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

22 OUTPATIENT HOSPITAL
A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

23 EMERGENCY ROOM – HOSPITAL
A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

24 AMBULATORY SURGICAL CENTER
A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

25 BIRTHING CENTER
A facility, other than a hospital's maternity facility or a physician's office, which providers a setting for labor, delivery and immediate post-partum care as well as immediate care of newborn infants.

26 MILITARY TREATMENT FACILITY
A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

31 SKILLED NURSING FACILITY
A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing or rehabilitative services but does not provide the level of care or treatment available in a hospital.

32 NURSING FACILITY
A facility which primarily provides to residents nursing care and related services for the

rehabilitation of injured, disabled or sick persons or, on regular basis, health-related care and services above the level of custodial care to other than mentally retarded individuals.

33 CUSTODIAL CARE FACILITY
A facility which provides room, board and other personal assistance services, generally on a long-term basis but does not include a medical component.

34 HOSPICE
A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.

41 AMBULANCE, LAND
A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

42 AMBULANCE, AIR OR WATER
An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

51 INPATIENT PSYCHIATRIC FACILITY
A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

52 PSYCHIATRIC FACILITY PARTIAL HOSPITALIZATION
A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full-time hospitalization, but who need broader programs than are possible from outpatient visits in a hospital-based or hospital-affiliated facility.

53 COMMUNITY MENTAL HEALTH CENTER
A facility that provides comprehensive mental health services on an ambulatory basis primarily to individuals residing or employed in a defined area.

54 INTERMEDIATE CARE FACILITY/MENTALLY RETARDED
A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or skilled nursing facility.

55 RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
A facility which provides treatment for substance (alcohol and drug) abuse to live-in resident who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

56 PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

NOTE: For TRICARE/CHAMPUS, this means a psychiatric residential treatment center for children and adolescents.

61 COMPREHENSIVE INPATIENT REHABILITATION FACILITY
A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include rehabilitation nursing, physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.

62 COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY
A facility that provides comprehensive rehabilitation service under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy and speech pathology services.

65 **END STAGE RENAL DISEASE TREATMENT FACILITY**
A facility other than a hospital, which provides dialysis treatment, maintenance and/or training to patients or care givers on an ambulatory or home-care basis.

71 **STATE OR LOCAL PUBLIC HEALTH CLINIC**
A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.

72 **RURAL HEALTH CLINIC**
A certified facility which is located in a rural medically underserved area that provides ambulatory, primary medical care, under the general direction of a physician.

81 **INDEPENDENT LABORATORY**
A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.

99 **OTHER UNLISTED FACILITY**
Other service facilities not identified above.

TYPE OF SERVICE CODES (CODES TO BE USED IN BLOCK 24C):

1	MEDICAL CARE	**A**	DME RENTAL/PURCHASE
2	SURGERY	**B**	DRUGS
3	CONSULTATION	**C**	AMBULATORY SURGERY
4	DIAGNOSTIC X-RAY	**D**	HOSPICE
5	DIAGNOSTIC LABORATORY	**E**	SECOND OPINION ON ELECTIVE SURGERY
6	RADIATION THERAPY	**F**	MATERNITY
7	ANESTHESIA	**G**	DENTAL
8	ASSISTANT AT SURGERY	**H**	MENTAL HEALTH CARE
9	OTHER MEDICAL SERVICE	**I**	AMBULANCE
		J	PROGRAM FOR PERSONS WITH DISABILITIES

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CONTACT YOUR REGIONAL TRICARE CONTRACTOR IF YOU NEED ASSISTANCE COMPLETING A TRICARE/CHAMPUS CLAIM OR IF YOU NEED INFORMATION ABOUT TRICARE/CHAMPUS.

HCFA Form 1500

The HCFA Form 1500 is available online, at
http://www.ochampus.mil/ClaimFoms/1500-90.pdf

DD Form 2527

The DD Form 2527 is available online, at
http://www.ochampus.mil/ProviderHandbook/DD2527.pdf

UB92

The UB92 Form is available online, at
http://www.ochampus.mil/ProviderHandbook/FormUB92.pdf